



Langone Medical Center

LISA PARK, M.D.

Eye Physician and Surgeon

Cataract Surgery

Laser Vision Correction

MEDICAL HISTORY QUESTIONNAIRE

Name _____

Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (prescription and over-the-counter): _____

Do you have any **allergies** to any medications? **YES NO**

If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.)

List any **surgeries** you had (cataract, appendectomy): _____

Do you **currently** have any problems in the following areas? If YES, please provide information.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENTAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/ IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)?

YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.) **YES NO**

Have you ever had a blood transfusion?.....**YES NO**

Do you drink alcohol? **YES NO** If YES how much? occasional 1/day 2-3/day 4+/day

Do you smoke? **YES NO** If YES how much? occasional 1/2pack/day 1 pack/day 1+pack/day How many years? _____

Physicians' Signature: _____ Date: _____