Patient Name: _____ Date: _____
DOB: _____ Age: _____
Sex: Male or Female Marital Status: _____

Long Island Ophthalmic Care, P.L.L.C.

230 Hilton Ave, Suite 118
Hempstead, New York 11550
Tel: 516-481-1570 Fax: 516-481-1786

Were you referred by another physician or patient?

_____

Past History: *Do you have or have you had any of the following problems or conditions? Please answer all questions – Indicate YES or NO. If the answer is YES, please provide a brief explanation.*

EYES			**EXPLANATION**
Cataract(s)	YES	NO	_____
Crossed Eyes (Strabismus)	YES	NO	_____
Eye Injury	YES	NO	_____
Eye Inflammation (Uveitis)	YES	NO	_____
Family History of Glaucoma	YES	NO	_____
Glaucoma	YES	NO	_____
Lazy Eye (Amblyopia)	YES	NO	_____
Laser Eye Surgery	YES	NO	_____
Type? When?			_____
Macular Degeneration	YES	NO	_____
Operative Eye Surgery	YES	NO	_____
Type? When?			_____
Retinal Detachment	YES	NO	_____

GENERAL HEALTH			Weight _____ Height _____
High Blood Pressure	YES	NO	_ _____
High Cholesterol	YES	NO	_____
Atrial Fibrillation	YES	NO	_____
Irregular or Slow Heartbeat	YES	NO	_____
Angina/Chest Pain	YES	NO	_____
Heart Attack	YES	NO	_____
Heart Murmur	YES	NO	_____
Rheumatic Heart Disease	YES	NO	_____
Congestive Heart Failure	YES	NO	_____
Asthma	YES	NO	_____
Emphysema/C.O.P.D	YES	NO	_____
Bronchitis	YES	NO	_____
Sinusitis/Nasal Allergies	YES	NO	_____
Sleep Apnea	YES	NO	_____
Heartburn/Gastroesophageal	YES	NO	_____
Peptic Ulcer Disease	YES	NO	_____
G.I Disease (i.e. Ulcerative Colitis)	YES	NO	_____
Hepatitis	YES	NO	_____

Kidney Disease (i.e. Renal Failure)	YES	NO	_____
Kidney Stones	YES	NO	_____
Prostate Disorder	YES	NO	_____
Diabetes	YES	NO	_____
Thyroid Dysfunction	YES	NO	_____
Dry Mouth	YES	NO	_____
Sickle Cell Disease	YES	NO	_____
Blood Clotting Disorder	YES	NO	_____
Anemia	YES	NO	_____
Arthritis (Rheumatoid or Osteo.)	YES	NO	_____
Rheumatologic Conditions (i.e. Lupus)	YES	NO	_____
Eczema/Rash	YES	NO	_____
Cancer	YES	NO	_____
Skin Cancer/Moles Removed	YES	NO	_____
Hearing Loss	YES	NO	_____
Vertigo	YES	NO	_____
Frequent Headaches (i.e. Migranes)	YES	NO	_____
Multiple Sclerosis	YES	NO	_____
Seizure Disorder (i.e. Epilepsy)	YES	NO	_____
Other Neurologic Disorder	YES	NO	_____
Stroke/Transient Ischemic Attack (TIA)	YES	NO	_____
Paralysis	YES	NO	_____
Anxiety	YES	NO	_____
Depression	YES	NO	_____
Other Psychiatric Disorder	YES	NO	_____
Are you or could you be pregnant?	YES	NO	_____
Do you smoke? How much?	YES	NO	_____
When did you start?			_____
When did you stop?			_____
Do you drink?	YES	NO	_____
How much per day			_____

Have you ever had any previous surgery other than eye surgery? YES NO

Type: _____ Date: _____

Type: _____ Date: _____

Should we be aware of any other matter regarding your overall health? YES NO

_____

Patient Signature: _____ Date: _____