

**Welcome to Central New York Eye Center!  
New Patient Intake**

**Medical History Questionnaire**

ACCOUNT # \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_

List any *medication and dosages* you currently take (prescription and over the counter):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

If YES, list the medications and reactions: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

List any *surgeries* you have had (cataract, tonsillectomy, appendectomy, etc.):

\_\_\_\_\_

\_\_\_\_\_

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

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.			
Difficulty Reading or Watching TV			
Difficulty Driving (day or night)			
Blurred Vision or loss of vision			
Loss of Side Vision			
Double Vision			
Difficulty with night vision			
Glare / light sensitivity			
Eye pain or soreness			
Foreign Body Sensation			
Excess tearing/watering			
Mucous Discharge			
Redness			

**Name:**

\_\_\_\_\_

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	YES	NO	Explanation Of Problem
Sandy / gritty sensation			
Itching			
Burning			
Dryness			
Tired Eyes			
Infection of Eye of Lid (blepharitis, stye)			
Crossed eyes, lazy eye			
Drooping eyelid			
<b>GENERAL / CONSTITUTIONAL</b>			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (High blood pressure, heart, etc.)			
RESPIRATORY (asthma, breathing problems, Emphysema, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal Diseases, etc)			
GENITAL, KIDNEY, BLADDER			
MUSCLE, BONES, JOINT (arthritis)			
SKIN (acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia etc)			
ENDOCRINE (diabetes, hypothyroid, etc)			
BLOOD/LYMPH (cholesterolemia, anemia, etc)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, Sjogrens, etc.)			

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Name: \_\_\_\_\_

