LINDENHURST EYE PHYSICIANS AND SURGEONS, P.C.

LINDY ☐
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HISTORY RECORD

DATE______________

PATIENT NAME:____ DATE OF BIRTH________________

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HEALTH:

Have you been treated for any medical conditions such as Diabetes, High Blood pressure or Arthritis?
NO__ YES__ If YES, please explain____

Have you been hospitalized or had surgery?
NO__ YES__ If YES, please explain____

Do you have any allergies to drugs or food?
NO__ YES__ If YES, please list____

Do you take any medications including eye drops?
NO__ YES__ If YES, please list____

Do any medical or eye conditions run in your family? (eg. High blood pressure, diabetes, cataracts, or glaucoma)
NO__ YES__ If YES, please explain____

Do you smoke? NO___ YES___ Drink alcohol? NO___ YES___
If YES, please explain____

If any of the following eye conditions apply to you please check with a brief explanation;

___WEARS GLASSES/CONTACTS____
___DECREASED VISION____
___BLIND SPOT (S) IN VISION____
___POOR SIDE/NIGHT/COLOR VISION____
___ABNORMAL LIGHT SENSITIVITY____
___HALOS AROUND LIGHT____
___RED/PUFFY EYES____
___DRY/ITCHY EYES____
___PRESSURE BEHIND EYES____
___ABNORMAL TEARING____
___DISCHARGE/CRUSTY EYES____
___FLUCTUATING/DOUBLE VISION____
___FLOATERS/JAGGED LINES IN VISION_______________________________________
___FLASHING LIGHTS IN VISION ____
___PAST EYE INJURY (SURGERY/LASER)_______________________________________
___LAZY EYE____
___ABNORMAL PUPIL____
___CORNEAL DISEASE/CONDITON____
___GLAUCOMA____
___RETINAL DISORDER/CONDITON____
___CROSSED EYES AS A CHILD____