Weill Cornell Medicine

NewYork-Presbyterian

Ophthalmology

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# Medical Questionnaire

Patient Name: ______________________________________________ Date of Birth: _____________

Last First Middle initial

Chief medical reason for this visit: ______________________________________________________

_____________________________________________________________________________________

Who referred you here? _______________________________________________________________

Name Address Tel no

Who is your primary care physician? ___________________________________________________

Name Address Tel no

List any eye conditions you have: ________________________________________________________

List any eye surgeries you have had (including laser procedures): ___________________________

_____________________________________________________________________________________

Do you wear contact lenses? ________ Hard Soft Bifocal Toric Brand: ______________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

General Medical History (check all that apply):

| | | |
|---|---|---|
| ☐ Asthma | ☐ Osteoarthritis | ☐ Psoriasis |
| ☐ Pulmonary disease | ☐ Migraine | ☐ Cold sores |
| ☐ Rosacea | ☐ Multiple sclerosis | ☐ Environmental *(allergies/ hay fever, etc.)* |
| ☐ Eczema | ☐ HIV | |
| ☐ Lupus | ☐ Chronic Hepatitis | ☐ Other _________ |
| ☐ Rheumatoid arthritis | ☐ Sickle cell | ______________________ |

**Continued on back ------>**

Please indicate [**X**] any MEDICAL conditions that you or a blood relative may have or had:

| | Macular Degeneration | Cataract | Glaucoma | Glaucoma Suspect | Keratoconus | Retinal Detachment | Blindness | Cancer | Stroke | Diabetes | Heart Disease | High Blood Pressure | Thyroid Disease | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self | | | | | | | | | | | | | | |
| Paternal Grandmother | | | | | | | | | | | | | | |
| Paternal Grandfather | | | | | | | | | | | | | | |
| Maternal Grandmother | | | | | | | | | | | | | | |
| Maternal Grandfather | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | |

Please list current medications with dosage & frequency (including eye medications):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Do you have any allergies to medications? ___________________________________________

**Please list prior surgeries (other than eye) Date of Surgery**

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Are you currently experiencing any of the following:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **Constitutional Symptoms**<br>Fever, Chills, Weight change, Sleep disturbance | | | **Genitourinary**<br>Kidney Stones, Urinary Frequency/ Urgency | | |
| **Skin**<br>Itching, Dryness, Rashes, Ulcers | | | **Endocrine**<br>Hormonal or Thyroidal problems, Cold/Heat Intolerance | | |
| **Ear, Nose, Mouth, Throat**<br>Deafness, Ear Infections, Vertigo, Mouth Lesions | | | **Musculoskeletal**<br>Arthritis, Muscle Pain, Back Problems, Swelling | | |
| **Neurological**<br>Headache, Seizure, Paralysis, Head Injury, Dizziness | | | **Hematologic/Lymphatic**<br>Anemia, Blood Clots, Bleeding Disorders | | |
| **Respiratory**<br>Shortness of Breath, Chronic Cough, Wheezing | | | **Psychiatric**<br>Depression, Anxiety, Psychosis, Mania | | |
| **Gastrointestinal**<br>Acid Reflux, Constipation, Diarrhea, Vomiting | | | **Cardiovascular**<br>Chest Pains, Palpitations | | |
| **Do you smoke?**<br>If yes, how often?<br>_______________ | | | **Do you drink?**<br>If yes, how often?<br>_______________ | | |

**"I ______________________________ authorize the use of photography/videography for medical purposes during this visit and consent to the use of this data for the advancement of medical knowledge and/or education, including publications. I understand that while these images may be identifiable, my name and demographic information, as well as protected health information will not be used."**

*Patient's signature:* __________________________________________________ *Date:* __________________

*Reviewed by M.D.:* __________________________________________________ *Date:* __________________

***If you are a Pediatric, ROP, or Strabismus Patient PLEASE CONTINUE to page 4*** **------------------------->**

# Pediatric, ROP, or Strabismus Patient Questionnaire

If you have previously been evaluated and treated for this condition, please provide details (including childhood medical and surgical eye treatments:

Name of physician Date Treatment (e.g. glasses, patching, surgery)

________________________________________________________________________________________

________________________________________________________________________________________

Please provide information about any other testing that has been done related to this condition (e.g. MRI, spinal tap) or attach records.

Test Date Result

________________________________________________________________________________________

________________________________________________________________________________________

**For Children under Age 18, please answer the following pertaining to your child's birth and medical history:**

Were there problems during pregnancy (infection, etc.)? ________________________________________

Were there problems during delivery (forceps, breech, twins)? ______________________________________

Did your child have to stay in the hospital? If so, please describe ____________________________________

Has he/she reached normal milestones? If not, please describe. ____________________________________

Was he/she born on time? If not, please describe (include weeks premature) ____________________________

What was the child's weight at birth? __________________________________________________

Eye exam in the hospital? Yes ☐ No ☐ If yes, Where? ____________________ Doctor's Name____________

Other medical conditions ____________________________________________________________

Other surgical procedures ____________________________________________________________

Who lives at home with the child? ______________________________________________________

Are there other parents/caregivers involved? If so, please describe: __________________________________

What grade is he/she in? ____________________________________________________________

Please indicate [**X**] if any blood relative may have or had any of the following:

| | *Self* | *Mother* | *Father* | *Sister(s)* | *Brother(s)* | *Other* |
|---|---|---|---|---|---|---|
| **Strabismus**<br>crossed" or "wandering" eyes | | | | | | |
| **Ambyopia**<br>Lazy eye | | | | | | |
| **Eye Surgery in Childhood** | | | | | | |
| **Glasses before age 6** | | | | | | |
| **Other Genetic Eye Diseases** | | | | | | |
| **ADDITIONAL NOTES:** | | | | | | |