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Medical & Surgical Eye Care
1825 Commerce St, 2nd Floor
Yorktown Heights, NY 10598

Eye & Medical History

Full Name_____ ***Today's Date***_____

Reason for today's exam?_____

Referring Doctor?_____

When was your last complete eye exam?_____ Doctors Name_____

Do you wear glasses? **YES** **NO**

Do you wear contact lenses? **YES** **NO**

Pharmacy Name & Number: _____

Do you need cataract surgery? **YES** **NO**

Doctor's Name_____

When was your last physical exam?_____

GENERAL HEALTH:

___Allergies
___Asthma/Pulmonary
___Diabetes
___Heart Disease
___Drug Sensitivities
___Skin Conditions
___Thyroid Conditions
___High Blood Pressure
___Low Blood Pressure
___Fainting
___Surgical Operations
___Pregnant
___Seizures
___Do you smoke? **YES** **NO**
___Other (Specify)_____

OCULAR HEALTH:

___Macular Degeneration___Family Hx
___Glaucoma Family Hx
___Cataracts Family Hx
___Eye Surgery
___Eye or head injuries
___Turned or crossed eye
___Flashes of light
___Floaters
___Other (specify)_____

VISUAL SYMPTOMS:

___Blur at distance
___Blur at near
___Eye strain
___Headaches
___Glare
___Rereading Words
___Losing place while reading
___Sensitivity to bright light
___Double Vision
___Eyes itch, burn, get red or tear

History of Stroke **YES** **NO**

COVID vaccine? (2 doses) **YES** **NO**

When?_____ EKG_____

Weight (lbs):_____ Height:_____

If you have diabetes who is your endocrinologist?_____

Are you presently taking medication? **Yes** **NO**
If Yes, Please list_____

Are you allergic to any medications? **YES** **NO** If Yes, Please list