Staten Island Ophthalmology (SIO)
Academic Eye Center (AEC)
John S. Kung, MD, FAAO, FICS

MEDICAL HEALTH QUESTIONNAIRE

Patients Name: ____

HAVE YOU EVER HAD? (Please check Yes or No)

Heart Trouble? ___Yes___No
Asthma or Breathing Problems? ___Yes___No
Diabetes? ___Yes___No
Stroke? ___Yes___No
High Blood Pressure? ___Yes___No
Epilepsy or Convulsions? ___Yes___No
A bad reaction to Local or General Anesthesia? ___Yes___No

Jaundice, Hepatitis or Liver Problems? ___Yes___No
Allergies or reactions to drugs? ___Yes___No
If Yes, Please list: ___________________________
Bleeding Tendency? ___Yes___No
Anxiety Problems? ___Yes___No
Chronic Back Problems? ___Yes___No
Abnormal EKG? ___Yes___No

EYE HEALTH HISTORY:
Date of Last Visit: ___________________________
Physician's Name: ___________________________
Date of Last Eye Exam: _______________________

PLEASE CHECK YES OR NO

Do you wear glasses or contacts? ___Yes___No
Color vision poor? ___Yes___No
Night Vision ___Yes___No
Discharge from eyes ___Yes___No
Fainting spells, blackouts ___Yes___No
Temporary loss of vision ___Yes___No
Migraine headaches ___Yes___No
Twitching Eyelid ___Yes___No

Bloodshot eyes ___Yes___No
Blurred vision ___Yes___No
Distance or Near ___Yes___No
Burning eyes ___Yes___No
Headaches ___Yes___No
Cataracts ___Yes___No
Loss of vision ___Yes___No
Dizzy Spells ___Yes___No
Double vision ___Yes___No
Dry Eye ___Yes___No
Eye Infection ___Yes___No

Eye strain ___Yes___No
Floaters or Spots ___Yes___No
Glaucoma ___Yes___No
Itching Eyes ___Yes___No
Light Sensitive ___Yes___No
Watering eyes ___Yes___No
Red eyes ___Yes___No
Seeing halos ___Yes___No
Seeing flashes ___Yes___No
Eye injury ___Yes___No
Vision poor ___Yes___No

Do You

Yes ____ No ____ Wear a hearing aid?
Yes ____ No ____ Have dentures, caps or bridges? If so, please circle.
Yes ____ No ____ Smoke? If so, how much? ___________________________________
Yes ____ No ____ Drink alcohol? If so, how much?_____________________________
Yes ____ No ____ Take any blood thinners? (ex. Aspirin, Coumadin, Ticlid, Persantin)
Yes ____ No ____ Take prescription medication? If yes, please list:___________________

Patients Signature: X_____________________________________ Date: _____________________