

**Binghamton Eye Associates, 33 Mitchell Ave. Binghamton, NY 13903 607-723-7586**  
**MEDICAL HISTORY QUESTIONNAIRE**

DATE: \_\_\_/\_\_\_/\_\_\_ NAME: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

ALLERGIES TO MEDICATIONS: LIST \_\_\_\_\_

**CIRCLE ALL MAJOR ILLNESSES THAT APPLY TO YOU PRESENT AND PAST:**

Elevated cholesterol	Thyroid	Migraine	Asthma/Emphysema/SOB	Other: _____
High blood pressures	Arthritis	Sinus	Heart Condition	_____
Diabetes	Lupus	Stroke	Depression/Anxiety	_____
Gastrointestinal problems	Anemia	Seizures	Kidney problems	_____

LIST ALL SURGERIES YOU HAVE HAD: \_\_\_\_\_

GENTLEMEN: Have you ever been on FLOMAX (tamsulosin) HYTRIN (terazosin) PROSCAR (finasteride) for prostate conditions? Please circle

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, PROVIDE ADDITIONAL INFORMATION.

	YES	NO	DETAIL
EYES (POOR VISION, EYE PAIN, TEARING, REDNESS, ETC).			
GENERAL / CONSTITUTIONAL (FEVER, HEAT STROKE, WEIGHT LOSS, WEIGHT GAIN, UNUSUALLY TIRED)			
EARS, NOSE, THROAT (HARD OF HEARING, STUFFY NOSE, EAR ACHE, COUGH, DRY MOUTH, ETC)			
CARDIOVASCULAR (HIGH BP, RACING PULSE, ETC)			
RESPIRATORY (CONGESTION, WHEEZING, SHORT OF BREATH, ETC)			
GASTROINTESTINAL (STOMACH UPSET, DIARRHEA, CONSTIPATION, HERNIA, ULCERS, GERD, DIVERTICULITIS)			
GENITAL, KIDNEY, BLADDER (PAINFUL URINATION, FREQUENT URINATION, IMPOTENCE, YELLOW JAUNDICE, ETC)			
FEMALES ARE YOU PREGNANT? NURSING?			
MUSCLES, BONES, JOINTS (JOINT PAIN, STIFFNESS, SWELLING, CRAMPS, ARTHRITIS, OSTEO ARTHRITIS)			
SKIN (ROSACEA, WARTS, GROWTHS, RASH, ETC)			
NEUROLOGICAL (NUMBNESS, HEADACHE, SEIZURES, PARALYSIS, ETC.)			
PSYCHIATRIC (ANXIETY, DEPRESSION, INSOMNIA, ADD)			
ENDOCRINE (DIABETES, HYPOTHYROID)			
BLOOD / LYMPH (BLEEDING, CHOLESTEROLEMIA, ANEMIA, PROBLEMS RELATED TO BLOOD TRANSFUSION)			
ALLERGIC / IMMUNOLOGIC (SNEEZING, SWELLING, ITCHING, HIVES, LUPUS, REDNESS, MRSA, ETC)			
CANCER			

**FAMILY HISTORY:** M = MOTHER F = FATHER S = SIBLING GP = GRANDPARENT

MACULAR DEGENERATION \_\_\_\_\_

GLAUCOMA \_\_\_\_\_

DIABETES \_\_\_\_\_

<b>SOCIAL HISTORY:</b> DO YOU DRINK ALCOHOL?	YES / NO	HOW MUCH? _____
DO YOU SMOKE?	YES/ NO	HOW MANY YEARS? _____
DO YOU DRIVE?	YES/ NO	
ANY BLOOD TRANSFUSIONS?	YES / NO	
WEIGHT	STABLE / GAIN / LOSS	