Levenson eye associates

LevensonEyeAssociates.com | 904-366-3781

Jeffrey H. Levenson, M.D.
Frank W. McDonald, M.D.
Hannah Miller, M.D.
Walter Smithwick, IV, M.D.
Samuel Homra, M.D.
Curtis Schmidt, O.D.
Ronald Singal, M.D.
Elizabeth McLeod, M.D.
William Knauer, M.D.

MEDICAL HISTORY

Name: _____ Date of Birth: _____ Date: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS?

☐ No ☐ Yes If yes, please list:

_____

_____

SOCIAL HISTORY:

Do you use any illicit drugs? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes If yes, how much: _____

Do you use tobacco products? ☐ No ☐ Yes If yes, how much: _____ For how many years: _____

OPHTHALMOLOGY HEALTH QUESTIONNAIRE

Please describe any concern or problem you have with your eyes:

_____

_____

_____

Do you wear: ☐ glasses ☐ contact lenses ☐ soft ☐ hard ☐ neither For: ☐ reading ☐ distance

Date of last eye exam _____

Please check any of the problems you have with your vision:

☐ poor vision ☐ double vision ☐ blurred vision ☐ poor night vision
☐ halos around lights ☐ see flashes of lights ☐ spots before eyes ☐ trouble identifying colors
☐ color blindness ☐ crossed eyes ☐ other *(please describe)*: _____

Please check any of the problems you have with your eyes:

☐ red or bloodshot ☐ itching, burning sensation ☐ eyes water a lot ☐ pain in eyes
☐ discharge like pus ☐ sensitive to light ☐ gritty sensation
☐ other *(please describe)*: _____

Have you ever had any eye injury? ☐ No ☐ Yes If yes, ☐ right ☐ left

Have you ever had eye surgery? ☐ No ☐ Yes If yes, ☐ right ☐ left
Type of Surgery:_____ Name of Eye Surgeon:_____

Do you have any known eye diseases? ☐ No ☐ Yes If yes, ☐ right ☐ left

Riverside Park Place
51 Oak Street
Suite 200
Jacksonville, FL 32204

Mandarin
3020 Hartley Road
Suite 190
Jacksonville, FL 32257

Orange Park
905 Park Avenue
Suite 104
Orange Park, FL 32073

Ponte Vedra Beach
120 A1A North
Suite 102
Ponte Vedra Beach, FL 32082

Knauer Building
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List any medications or eye drops you are currently taking *(prescription and over-the-counter)*

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

List any **major illnesses** (diabetes, high blood pressure, glaucoma, hart disease, lung disease, cancer) or injuries:

List any **surgeries** you have had (cataract, appendectomy):

Do you **currently** have any problems in the following areas? If yes, please provide additional information:

	YES	NO	DETAILS
GENERAL: (fever, chills, weight change, malaise, cancer)	☐	☐	
EARS, NOSE, THROAT: (hard of hearing, nose bleeds, ear ache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR: (high B.P., chest pain, heart disease, etc.)	☐	☐	
RESPIRATORY: (short of breath, wheezing, etc.)	☐	☐	
GASTROINTESTINAL: (diarrhea, constipation, blood in stool, ulcers, stomach upset, loss of appetite, hepatitis, etc.)	☐	☐	
GENITAL, KIDNEY, BLADDER: (painful urination, frequent urination, blood in urine, jaundice, etc.)	☐	☐	
FEMALES: Are you pregnant? Nursing?	☐	☐	
MUSCLES, BONES, JOINTS: (joint pain, arthritis, cramps, swelling, stiffness, etc.)	☐	☐	
SKIN: (rash, growths, etc.)	☐	☐	
NEUROLOGICAL: (numbness, headache, seizure, stroke, etc.)	☐	☐	
PSYCHIATRIC: (depression, anxiety, insomnia, etc.)	☐	☐	
ENDOCRINE: (diabetes, thyroid disease, excessive thirst, etc.)	☐	☐	
BLOOD/LYMPH: (bleeding, high cholesterol, anemia, etc.)	☐	☐	
ALLERGIC/IMMUNOLOGIC: (itching, hives, lupus, rheumatoid arthritis, HIV/AIDS, etc.)	☐	☐	

Signature of Person Completing this Form

Relationship to Patient

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