COLUMBIA EYE CLINIC PATIENT HISTORY

NAME ____ **DATE OF BIRTH** ____/____/_____

Name of current family doctor: ____

CHECK (√) IF YOU HAVE HAD ANY OF THE FOLLOWING EYE PROBLEMS:

Blurred Vision ____ Loss of Vision ____ Double Vision ____ Dry Eyes ____

Light Sensitive ____ Light Flashes ____ Floaters ____ Eye Surgery ____

Droopy Eyelids ____ Crossed Eyes ____ Cataracts ____ Tearing ____

Eye Pain ____ Headaches ____ Retinal Disease ____ Discharge ____

Laser Treatment ____ Glaucoma ____ Redness ____ Macular Degeneration ____

CHECK (√) IF YOU HAVE/OR HAVE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS:

Heart Trouble ____ Breathing Trouble ____ High Blood Pressure _______

Stomach Trouble ____ Cancer ____ Bladder/Kidney/Genital Problems _______

Skin Problems: ____ Allergies ____ Bone/Joint/Muscle Problems _______

Nerve Problems ____ Mental Problems ____ Gland/Blood/Lymph Problems _______

Diabetes ____ Immune Disorder ____ Other (Please explain) __________________

Do you smoke? ____ Do you drink alcohol? ____ Are you pregnant? ____ Are you breastfeeding? ____

Are you able to care for yourself? ____________

CHECK (√) IF SOMEONE IN YOUR FAMILY HAS / OR HAS HAD:

Diabetes ____ Retinal Diseases ____ Glaucoma ____ Cataracts ____

Any other eye Diseases? ____ Please explain____

ARE YOU ALLERGIC OR SENSITIVE TO LATEX OR RUBBER PRODUCTS? YES______ NO_______

Pharmacy Name: __________________ **Address:** ____

Please List all Medications you are currently taking, along with the Dosage and Frequency: ________________

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List All Medications you are Allergic to: ____

PATIENT SIGNATURE ____ DATE _______________

PHYSICIAN'S SIGNATURE ____ DATE _______________

***Refraction fees are not covered by most insurance companies. Therefore the refraction fee of $40.00 may be the responsibility of the patient.**

An additional fee will be charged for completion of highway forms