

COLUMBIA EYE 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: _____

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 \$50.00 may be the responsibility of the patient.**

An additional fee will be charged for completion of highway forms