Columbus Ophthalmology associates

Name:______________________________ DOB:____________________ Date:_________

Past History: *Check all that apply*

☐ Allergy problems ☐ Crohn's Disease ☐ Heart Disease ☐ Neuro problems
☐ Anemia ☐ Depression, Anxiety ☐ High blood pressure ☐ Seizures
☐ Arthritis ☐ Diabetes ☐ High cholesterol ☐ Sexually transmitted infections
☐ Asthma ☐ Emphysema ☐ Kidney problems ☐ Stroke
☐ Autoimmune disease ☐ Glaucoma ☐ Liver problems ☐ Thyroid Disease
☐ Cancer ________________ ☐ Headaches ☐ Migraines
☐ Other problems not listed above:____

Hospitalizations:____

Eye Surgeries		**Other Major Surgeries**	

Medication List: Please Attach Extra List If Needed

Technician	Date	Medication, Vitamins, Supplements	Dosage	Frequency

Do you **now** or have you **ever** taken: Flomax, Cardura, Hytrin, Uroxatral, or Saw Palmetto ☐ Yes ☐ No

Latex Allergies: ☐ Yes ☐ No

Eye History	**Patient**	**Family Member**
Cataract		
Corneal		
Glaucoma		
Retinal		
Lazy/Crossed Eye		
Injuries		
Other		

Date	**Medication Allergies**

Please Complete Both Sides

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Name:______________________________ DOB:____________________ Age:________ Date:_________

Review of Systems:

Please indicate any problems in the following areas that are bothering you.

Circle all that apply:

General: fever, chills/sweats, weight loss, fatigue

Eyes: blurred vision, redness, itching, discharge, flashes of light, floaters

Cardiovascular: chest Pain, rapid heart beat

Pulmonary: cough, shortness of breath,

Digestive: constipation, vomiting, diarrhea, nausea

Bladder: increased frequency, pain with urination

Muscle: joint pains, muscle weakness, muscle pain

Skin: rashes, hives, itching

Neurological: headaches, dizziness, weakness, numbness, tingling, loss of balance, fainting

Psychological: anxiety, depression, sadness

Hematologic/Lymphatic: bruising, swelling, bleeding

Do you have Advanced Directives (Living Will, Durable Power of Attorney)? ☐ Yes ☐ No

Do you use any tobacco products? ☐ Yes
☐ No

Do you drink alcohol? ☐ Yes ☐ No
How many drinks per week? _____________

Any illegal drug use? ☐ Yes ☐ No
Type?__________________________________

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Immunizations:	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
Influenza						
Pneumonia						
Shingles						

Occupation:____

Please Complete Both Sides

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