

**COLUMBUS EYE ASSOCIATES
MEDICAL INFORMATION SHEET**

Today's Date: _____ Patient Name: _____ Age: _____

-If you were referred by a doctor or clinic, provide name and office number: _____

-Primary Care Physician/Office Number _____

-Please check the following medical conditions that apply to you: (even if you are on medications for them)

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes-Type I (year of onset _____) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes-Type II (year of onset _____) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bell's Palsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer (type _____) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lupus | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sjogrens | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Other: _____ | | |

-Are you currently pregnant? YES or NO. If yes, please give due date: _____ Are you currently nursing? YES or NO

***Have you ever taken Flomax (tamsulosin), Hytrin, or any bladder intolerance medications? YES or NO?

-Have you ever had an **EYE or head injury**? YES or NO? If yes, specify: _____

-Have you ever had **EYE** surgery? YES or NO? If yes, list what type of eye surgery and year performed: _____

-Have you ever had any **general surgeries or hospitalizations** (this DOES NOT include eye surgery)? YES or NO. If yes, list _____

-If there are any **EYE diseases or medical illnesses in your FAMILY** that could be hereditary, list disease/illness and relation to patient: _____

-Are you allergic to any medications? YES or NO? If yes, list the medications you are allergic to and reaction: _____

-List all **current EYE DROPS**. **INCLUDE ALL OVER THE COUNTER EYE DROPS AND EYE SUPPLEMENTS**: _____

-List all of your current **systemic** medications including milligrams. **INCLUDE OVER THE COUNTER VITAMINS AND SUPPLEMENTS**

-Pharmacy Name: _____ Location: _____ Phone# _____

-Do you use tobacco products? YES or NO. If yes, what type and how often? _____

-Do you consume alcohol? YES or NO. If yes, how often? _____

**If you are having a problem today with your eyes or vision, specify problem on the line provided or check from the following: _____

- | | |
|--|--|
| <input type="checkbox"/> Visual loss? (sudden or gradual) | <input type="checkbox"/> Burning sensation in the eyes? |
| <input type="checkbox"/> Blurred vision at near? | <input type="checkbox"/> Itching in and around the eyes? |
| <input type="checkbox"/> Blurred vision at far? | <input type="checkbox"/> Dry eyes? |
| <input type="checkbox"/> Difficulty reading road signs? | <input type="checkbox"/> Watering/Tearing? |
| <input type="checkbox"/> Difficulty seeing when working with small tools or objects? | <input type="checkbox"/> Pain and/or irritation? |
| <input type="checkbox"/> Blurred vision at mid-range? | <input type="checkbox"/> Matter or discharge? |
| <input type="checkbox"/> Glaucoma? | <input type="checkbox"/> Floaters? |
| <input type="checkbox"/> Macular Degeneration? | <input type="checkbox"/> Flashes of light? |
| <input type="checkbox"/> Cataracts? | <input type="checkbox"/> Crossed eyes? |
| | <input type="checkbox"/> Double Vision? |