

**COLUMBUS EYE ASSOCIATES  
MEDICAL INFORMATION SHEET**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What problem brought you to our office? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an eye injury or surgery?  Yes  No When: \_\_\_\_\_

Doctor: \_\_\_\_\_

List all EYE medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is your family doctor? \_\_\_\_\_

List all of your medications: \_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Is there any eye disease, such as glaucoma or retinal detachment, in your family?  Yes  No

If Yes, please specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Visual loss?  | <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"/> Double vision?                  |
| <input type="checkbox"/> Difficulty working with small tools or with needlepoint?          | <input type="checkbox"/> Floaters?                       |
| <input type="checkbox"/> Do bright lights cause glare, reduce vision, or cause discomfort? | <input type="checkbox"/> Crossed eyes?                   |
|  | <input type="checkbox"/> Double vision?                  |

Do you have any of these medical conditions?

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS  |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung disease   | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other: _____        |   |                                    |

List any surgeries that you have had in past:

Surgery: _____	Date: _____
Surgery: _____	Date: _____
Surgery: _____	Date: _____
Surgery: _____	Date: _____
Surgery: _____	Date: _____

List any medication allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken Flomax (tamsulosin), Hytrin, or any bladder intolerance medications?  Yes  No

If Yes, for how long? \_\_\_\_\_