COLUMBUS EYE ASSOCIATES MEDICAL INFORMATION SHEET (PLEASE COMPLETE ENTIRE FORM)

Patient Name: _____ Today's Date: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Primary Care Physician: _____Phone #_____

Referring Doctor/Clinic: _____Phone # _____

Check any **ACTIVE** medical conditions that apply to you:

___Diabetes or Pre-Diabetes. If you are diabetic or pre-diabetic, what is your last known HgA1C? _____ Last BS reading? _____

___High Cholesterol	___Multiple Sclerosis	___Cataracts	___HIV/AIDS
___Thyroid Disease	___Heart Disease	___Glaucoma	___Shingles
___High Blood Pressure	___Asthma	___Macular Degeneration	___Hepatitis
___Low Blood Pressure	___Sjogrens	___Migraines	___ Meningitis
___Rheumatoid Arthritis	___Lupus	___Bells's Palsy	___Cancer (type/stage):_____

___OTHER: _____

***FEMALES ONLY:** Are you currently pregnant? ___YES or ___NO. If yes, due date? _____
Are you currently nursing? ___YES or ___NO

Have you ever had trauma to your head or eye(s)? ___YES or ___NO. If yes, please explain below:

_____

List any previous surgeries, including eye surgery **AND** any recent hospitalizations: _____ _____

_____ _____ _____ _____ _____ _____

***Have you ever taken Flomax (tamsulosin), Hytrin, or any bladder intolerance medications? ___YES or ___NO?**
These medications may cause an issue with the dilation process of the pupils, even if you are no longer taking them

Family History: Does anyone in your family have a history of medical problems? (if so, please explain)

Mother:_____Father:_____
Sibling(s):_____Children:_____
Maternal Grandparent(s)_____Paternal Grandparent(s)_____

List any medications that you have had an **allergic reaction** to: _____ _____ _____ _____

List all of your current medications, over-the-counter medications, vitamins, supplements **AND** eye drops below:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Local Pharmacy: _____Address:_____ Phone #_____

Mail-Order Pharmacy: _____Phone #_____

Are you a current smoker? ____YES or ___NO. If no, are you a former smoker? ____YES or ___NO
Do you consume alcohol? ___YES or ___NO. If so, how often? ____Daily ___Social Occasions ___Rare

If you are having a problem today with your eyes or vision, specify problem on the lines provided below and/or check from the following:

_____

_____

____ Visual loss, sudden/gradual	____Floaters	____Matter/Discharge	___Burning
____ Blurred vision	____Flashes of light	____Watering/Tearing	___Redness
____ Double Vision	____Pain and/or irritation	____Itching	___Dryness