

DATE: _____

COLUMBIA EYE CLINIC PATIENT HISTORY

NAME _____ BIRTH DATE ____ / ____ / ____

Name of family doctor: _____

CHECK () IF YOU HAVE ANY OF THE FOLLOWING EYE PROBLEMS:

- Blurred Vision _____ Loss of Vision _____ Double Vision _____
- Tearing _____ Discharge _____ Redness _____ Dry Eyes _____
- Light Sensitive _____ Light Flashes _____ Floaters _____
- Droopy Eyelids _____ Crossed Eyes _____
- Eye Pain _____ Headaches _____
- Cataracts _____ Glaucoma _____
- Retinal Disease _____ Macular Degeneration _____
- Eye Surgery _____ Laser Treatment _____

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 able to care for yourself? _____

LIST ALL MEDICATIONS YOU TAKE: _____

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO: _____

CHECK () IF SOMEONE IN YOUR FAMILY HAS / OR HAS HAD:

- Diabetes _____ Retinal Diseases _____ Glaucoma _____ Cataracts _____
- Any other eye Diseases? _____ Please explain _____

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

* Refraction fees are not covered by most insurance companies. Therefore the refraction fee of \$25.00 is the responsibility of the patient.

An additional fee will be charged for completion of highway form.