COLUMBUS EYE ASSOCIATES MEDICAL/HEALTH INFORMATION FORMS TO COMPLETE-PAGE 1 of 2

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Preferred Language:_____ Race:_____ Gender:_____
Primary Care Physician:_____ Referring Doctor: _____
Rheumatologist:_____Cardiologist:_____
Endocrinologist:_____ Neurologist:_____
OTHER:_____

LOCAL PHARMACY:_____**Zip Code:**_____**Phone:**_____
MAIL ORDER PHARMACY:_____**Zip Code:**_____
**Do we have your permission to electronically import your current medications from the pharmacy? YES or NO*
If you have a copy of your current medications including OTC, Vitamins and Supplements, please provide to front desk staff to make a copy for our records. If not, please list below:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Please list current eye drops/ointment/supplements: _____
_____

Drug Allergies:

□ No known drug allergies
Please list drug allergies, reaction and severity below:
_____Reaction:_____ Severity:_____
_____Reaction:_____ Severity:_____
_____Reaction:_____ Severity:_____

Medical History: Please check the following that apply

□Diabetes (type/age of onset/A1C)_____ □Kidney Problems □Renal Failure □Dialysis
□COPD □ Sleep Apnea □Uses CPAP Machine □Asthma □Use of Oxygen Tank □Thyroid Disease
□ Rheumatoid Arthritis □ Lupus □ Sjogren's Syndrome □Autoimmune Disorder □Plaquenil Use (onset_____)
□Atrial Fibrillation □Heart Disease □High Blood Pressure □High Cholesterol □Flomax/Tamsulosin Use
□Pacemaker □Defibrillator □Headaches □Migraine □Seizure Disorder □Dementia □Alzheimer's
□Pituitary Tumor □Brain Tumor □Stroke □Muscular Dystrophy □ Multiple Sclerosis □Slow Healer
□Parkinson's Disease □Tremors □Bell's Palsy □Bleeding disorders □Keloid Prone □Cold Sores/Fever Blisters
□Problems with Anesthesia (explain)_____
□HIV/AIDS □Hepatitis (Type:____) □Shingles □Other:_____
**Do you have a disability which requires assistance with your daily activities? YES or NO

Family History:

**Is there a family history of: □Glaucoma □Macular Degeneration □Fuch's Dystrophy □Retina Problems
□Autoimmune Disease □Cancer □Diabetes □Stroke □Neurological Problems
OTHER:_____

Social History:

Occupation:_____ If you are a student, what grade:_____
Smoking/Tobacco Use: □ daily □some days □former smoker □ never smoker
Alcohol Use: □daily □rare □occasional □socially □never
*FEMALES**Are you currently pregnant? YES, due date:_____ or NO **Are you currently nursing? YES or NO*

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Current Optometrist:_____ Current Ophthalmologist:_____

***Please complete medical records release form at front desk to have previous eye care records released to our clinic if necessary. This is imporant for glaucoma patients**

Have you been diagnosed with any of the following:

□Cataracts □Glaucoma □Macular Degeneration □Retinal Disease □Amblyopia □Strabismus

OTHER:_____

**History of Eye Trauma? (explain)_____

**History of Eye Surgery? (list details)_____

Do you wear glasses?_____ Do you wear contacts?_____Soft Lenses or Hard Lenses

What is the main reason for your visit today? If for a specific problem, which eye(s) and when did issue start:

_____

_____

_____

**Dilation drops may need to be used for your eye exam today. Dilation drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. You will be given a pair of disposable sunglasses to help with some of the symptoms from the dilation. If you wish to defer the dilation, please inform your doctors assistant. Please note, certain conditions REQUIRE dilation and will be discussed with you by the doctor or assistant.*

****For New Patients Requesting a Contact Lens Prescription****

**If you have your contacts in today, the fit and condition will be checked by the doctor or assistant prior to removing them. If you are happy with the contacts and they are fitting well, you may stay in your current brand, base curve and diameter. In order to process the prescription, you will need to provide your current contact lens information (brand, base curve, diameter and power). This can be found on your previous contact lens prescription or on the box. If the contacts fit well but you need a change in the power, you will receive a set of trial lenses to confirm visual acuity prior to dispensing the prescription.

**If your contacts are not fitting well and causing an issue to the health of your eyes, you will need to be refit prior to receiving the contact lens prescription. Trial lenses will be ordered to your specific exam information. Once the lenses arrive, you will need to try them for a few days then return for a visit with the optical assistant in order to confirm you are satisfied with the contacts and that they are fitting well.

**If you have never worn contacts before and would like to be fit, once the doctor approves, additional measurements will be taken and trial lenses will be ordered. Once they arrive, you will need to schedule an appointment with the optical assistant for a New Dispense to show you how to insert, remove, care and handling. Once you perform tasks properly, you will be given the trial pair to take home. You will need to return for an appointment with the optical assistant WITH THE CONTACTS IN to verify the vision and fit prior to releasing the contact lens prescription.

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