

Columbus Laser and Cataract Center - Health Questionnaire

General Health Information		
Have you been diagnosed with:	Yes	No
Arthritis		
Asthma / Chronic Bronchitis		
Bleeding disorders		
Cancer		
Diabetes		
Heart Trouble		
Hepatitis		
High blood pressure		
Kidney / Bladder problems / Prostate		
Lupus		
Multiple Sclerosis		
Sinus disorder		
Skin disorder (bruising, rashes)		
Stroke		
Thyroid disorder		
Tuberculosis		
Do you smoke? # packs/day =		
Do you drink alcohol? # glasses/day =		
Other:		

Eye Information		
Do you have a history of:	Yes	No
Blurry vision		
Burning		
Cataracts		
Color Vision Problems		
Distorted vision / Halos around lights		
Double vision		
Dryness		
Eye Injuries		
Eye pain		
Eyelid swelling		
Flashes of light		
Floaters		
Glare / Light sensitivity		
Glaucoma		
Loss of central vision		
Loss of side vision		
Macular Degeneration		
Redness		
Other:		

Current Medications: Dosage & Frequency			<input type="checkbox"/> None
1.	4.	7.	
2.	5.	8.	
3.	6.	9.	

Eye Meds: Dosage & Frequency
1.
2.
3.

Surgeries & Hospitalizations:
1.
2.
3.

Eye Surgeries: <input type="checkbox"/> None
1.
2.
3.

Are you allergic to any medications? Yes No List: _____
 Are you allergic to latex or adhesive? Yes No

Do you have a family history of:	Yes	No	Do you have a family history of:	Yes	No
Blindness			High Blood Pressure		
Cancer			Heart Disease		
Cataract			Macular Degeneration		
Diabetes			Lazy eye / Strabismus		
Eye Tumor			Retinal tear / detachment		
Glaucoma			Other:		

Social History: Marital Status – S ___ M ___ W ___ D ___ Occupation: _____ Male ___ Female ___

Print Name: _____ Signature: _____ Date: ___/___/___

Office Use	Initials						
	Date						