WELCOME TO COLUMBIANA VISION CARE

PLEASE COMPLETE THE FOLLOWING:

| Name (last, first): | | Date of Birth | h:/ | /_ | |
|--|----------------------------|---------------------------------|------------|--------|--------|
| Address: | | City: | _ Zip Cod | e: | |
| Home Phone: () | Cell Phone: () | P | reference: | ☐ Home | □ Cell |
| Insurance (Medical/Vision): | | SS# (age 21&ove | er) | | |
| Last EYE Doctor/Location: | | Date of last | t EYE exar | n:/_ | / |
| Primary Care Physician/Location: | | Date of last PHYS | ICAL exar | n:/_ | / |
| Pharmacy/Location: | Emplo | yer/Occupation: | | | |
| SPECTACLE / CONTACT LENS | | | | | |
| Do you wear glasses? □ Yes □ No □ Full T | ime □ Part Time □ Di | stance Only Reading Only | / □ Multi | focal | |
| How old are your current glasses? | | | | | |
| Do you wear contact lenses? ☐ Yes ☐ No | Brand of Contact Lens: | | | | |
| Computer use: How many total hours per day do | you use a computer, cell p | shone, tablet, or play video ga | mes? | | |
| □ 0-2 hours □ 2-4 hours □ 4- | 6 hours □ more than 6 h | ours | | | |
| Do you use computer glasses? ☐ Yes ☐ No | | | | | |
| What sports/hobbies do you participate in? | | | | | |
| Do you wear any special eyewear for your sport/l | | | | | |
| What is the MAIN reason for your visit today? _ | | | | | |
| Do you have any other visual / eye problems? _ | | | | | |
| REVIEW OF SYSTEMS Are you currently | experiencing any of the | following symptoms? | | | |

Today's Date: ____/___/___

☐ Please check here if ALL review of systems is NO

| Category | Current Symptoms | Yes | Category | Current Symptoms | Yes | Category | Current Symptoms | Yes |
|------------------|----------------------------|-----|---------------------------|-------------------------|-----|-----------------|---------------------------------------|-----|
| Constitutional | Fever | | Genitourinary | Blood in urine | | Psychiatric | Disorientation | |
| | Unexplained weight loss | | • | Difficulty urinating | | | Memory lapses | |
| | Unexplained fatigue | | Head | Sore throat | | | Ongoing depression | |
| Cardiovascular | Chest pain | | | Hearing loss | | Respiratory | Wheezing | |
| | Difficulties with exertion | | | Hoarse voice | | | Shortness of breath | |
| | Irregular heart- beat | | | Loss of smell | | | Persistent cough | |
| Endocrine | Increased urination | | | Sinus congestion | | Musculoskeletal | Unexplained muscle pain | |
| | Increased appetite | | Hematologic/ Lymphatic | Bleeding problems | | | Joint pain/ restricted movement | |
| | Increased thirst | | | Swollen glands | | | Lower back pain | |
| | Neck pain | | | Easy bruising | | Neurologic | Muscle weakness | |
| Gastrointestinal | Indigestion | | Integumentary (Skin) | Unexplained skin rashes | | | Tingling in extremities | |
| | Constipation | | | Dry skin | | | Headaches | |
| | Diarrhea | | | Itching of skin | | | Dizziness | |
| | Blood in stool | | | Pigmented skin | | | Dimming vision | |

MEDICATIONS Please include all medications, including inhalers, contraceptives, and over the counter

| Medication Name | Purpose | Medication Name | Purpose |
|--------------------------|---------|-----------------|---------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Over-the-counter/Topical | | Eye drops | |
| | | | |
| | | | |
| | | | |

ALLERGIES

| Medication(s) | Seasonal | Other |
|---------------|----------|-------|
| | | |
| | | |
| | | |

PLEASE CHECK ONLY BOXES THAT APPLY. UNCHECKED BOXES WILL MEAN "NO".

EYE HISTORY

| Condition | Self | Family | |
|---|------|--------|----------|
| | Yes | Yes | Relation |
| Eye Turn/Strabismus/Lazy Eye | | | |
| Childhood Cataracts | | | |
| Glaucoma/Suspect | | | |
| Macular Degeneration | | | |
| Retinal Tear/Detachment | | | |
| Dry Eye | | | |
| Previous Eye Injury | | | |
| Other Eye Condition(s) | | | |
| Previous Eye Injection | | | |
| Lasik/Refractive Surgery | | | |
| Previous Eye Surgery | | | |
| Elective / Other Facial Procedures | | | |

SOCIAL HISTORY

| | Yes |
|-----------------------|-----|
| Drink Alcohol | |
| Smoke - Past | |
| Smoke - Currently | |
| Recreational Drug Use | |

REPRODUCTIVE HEALTH

| | Yes |
|----------------------|-----|
| Pregnant - Currently | |
| Nursing - Currently | |
| | |
| | |

MEDICAL HISTORY

| Condition | Self | Family | |
|--|------|--------|----------|
| | Yes | Yes | Relation |
| Diabetes | | | |
| High Blood Pressure | | | |
| Elevated Cholesterol | | | |
| Heart Disease / Heart Attack | | | |
| Sleep Apnea | | | |
| Migraine | | | |
| Thyroid Disorder | | | |
| Stroke | | | |
| Cancer Type(s): | | | |
| Asthma/COPD | | | |
| Kidney Disease | | | |
| Arthritis Type(s): | | | |
| History of COVID-19 (Date of infection): | | | |
| Other: | | | |

| I verify that the information contained on this form is current. | Patient Signature: | | | |
|--|--------------------|---|---|--|
| | . | , | , | |
| | Date: | / | / | |