Columbus Laser and Cataract Center - Health Questionnaire

General Health Information		
Have you been diagnosed with:	**Yes**	**No**
Arthritis		
Asthma / Chronic Bronchitis		
Bleeding disorders		
Cancer		
Depression		
Diabetes		
Dialysis		
Heart trouble		
Hepatitis		
High blood pressure		
High cholesterol		
Kidney / Bladder problems / Prostate		
Lupus		
Multiple Sclerosis		
Skin Disorder		
Stroke		
Thyroid disorder		
Tuberculosis		
Other:		

General Health Information con't…		
	Yes	**No**
Do you smoke? # pack/day =		
Do you drink alcohol? # glasses/day =		
Family History		
Do you have a family history of:	**Yes**	**No**
Blindness		
Cancer		
Cataract		
Diabetes		
Eye Tumor		
Glaucoma		
High Blood Pressure		
Heart Disease		
Macular Degeneration		
Lazy Eye / Strabismus		
Retinal Tear / Detachment		
Other:		

Current Medications: Dosage & Frequency		❑None
1.	4.	7.
2.	5.	8.
3.	6.	9.

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

Surgeries & Hospitalizations:
1.
2.
3.

Eye Surgeries: ❑None
1.
2.
3.
4.
5.
6.

Are you allergic to any medications? ☐ Yes ☐ No

List: ____

Allergic to: **Latex:** ☐ Yes ☐ No **Adhesive:** ☐ Yes ☐ No

Social History: Marital Status ☐ S ☐ M ☐ D ☐ W Occupation: ________________ ☐ Male ☐ Female

Print Name: ___________________________________ Signature:_________________________________ Date: ___/___/___

Office Use	Initials						
	Date						

Pre- Operative Drops Used: Office Use	