Columbia Eye Associates

Eye Surgeons and Physicians

Lasik Vision Correction & Corneal and External Eye Disease

Dr. Rajiv Luthra

Patient Registration Form

Name: _____

Address: _____

City: _____State: _____Zip:_____

Cell Phone: _____Work Phone: _____

Gender: ☐ M ☐ F Date Of Birth: _____/ _____/ _____

Social Security Number: _____- _____- _____

Email: _____

Emergency Contact

Name: _____Phone:_____

Relationship: _____

Primary Care Physician

Name: _____Phone:_____

If you are not the insurance card holder:

Card holder name: _____

Card holder date of birth: _____

Our practice can send prescriptions electronically to your pharmacy. This means a safer and more efficient prescribing process for you. If you would like us to send your prescriptions, please give us the following information.

Pharmacy Name: _____

Pharmacy Address: _____

City: _____State:_____ Zip Code: _____

Pharmacy Phone: _____

Primary reason for today's visit: _____

_____

Do you currently have the following symptoms with your eyes?

Check all that apply:

☐ Loss of vision
☐ Blurred Vision
☐ Loss of Side Vision
☐ Double Vision
☐ Itching
☐ Burning
☐ Redness
☐ Gritty Feeling
☐ Dryness
☐ Pain
☐ Discharge
☐ Tearing
☐ Glare
☐ Light Sensitivity
☐ Halos
☐ Stye
☐ Soreness
☐ Infection of Eyelid/ eyelashes

☐ Difficulty with Night/Day Vision
☐ Difficulty with vision when reading
☐ Difficulty with vision when outdoors

Major Surgical Procedures: _____

_____

_____

Contact Lens Brand: _____

Contact Lens Power: Right _____Left_____

Are you interested in any of the following: Check all that apply?

☐ Botox ☐ Filler ☐ Upneeq (for droopy eyelids)

Please check all that apply:

Eyes
- ☐ Previous Surgery
- ☐ Contact Lens Wear
- ☐ Pain
- ☐ Double Vision
- ☐ HX of Cross/Lazy Eye
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Flashes
- ☐ Floaters

Ear, Nose and Throat
- ☐ Hard of hearing
- ☐ Ringing in Ears
- ☐ Vertigo

Psychiatric
- ☐ Anxiety/ Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/ Vomiting
- ☐ Jaundice/ Hepatitis

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat

Neurological
- ☐ Seizures
- ☐ Weakness/ Paralysis
- ☐ Numbness
- ☐ Tremors

Blood/ Lymph Nodes
- ☐ Easy Bruising
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

Musculoskeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain/ Swelling

Skin
- ☐ Rash/ Sores
- ☐ Lesions
- ☐ Hives/ Eczema

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Running Nose
- ☐ Sinus Pressure

Endocrine
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Sweating

Signature: _____Date: _____

Health History:

Please check all that apply:

☐Overall Healthy
☐ Herpes Simplex
☐ HIV/AIDS
☐ Syphilis
☐ MRSA
☐ Chicken Pox
☐ Herpes Zoster/ Shingles
☐ Meningitis
☐ Heart Disease
☐ Toxoplasmosis
☐ Hepatitis A/ B/ C
☐ Histoplasmosis
☐ Cancer
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes

Other: _____

Family History:

Diabetes: _____Stroke:_____

Blindness: _____Macular Degeneration: _____

Arthritis: _____Cancer:_____

Tuberculosis: _____Cataract:_____

Retinal Disease: _____Heart Disease: _____

Glaucoma: _____High Blood Pressure: _____

Other: _____

Social History:

Smoking: ☐ Everyday Smoker ☐ Sometimes Smoker ☐ Former Smoker ☐ Never

Alcohol Use: ☐ Yes ☐ No If yes, how much and how often:_____

Drug Use: ☐ Yes or ☐ No If yes, how much and how often:_____

Current Medication(s): _____

_____

Medication Allergies: _____