



PATIENT QUESTIONNAIRE

The sole purpose of this questionnaire is to assist our physicians and staff in your evaluation, diagnosis, and recommended treatment.

Patient: _____ Date of Birth: _____

Present or past occupation: _____

Have you previously been seen by Doctor: Collins Jones Rosen Johnson Alessi

How did you hear about Collins Vision? _____

Who did you bring with you today? _____

Have any of your family members ever had surgery with Collins Vision? Yes No

If yes, what kind of surgery? _____

Do you wear contacts? Yes No If yes: Soft Toric RGP Date Last Worn: _____

Do you have prism in your glasses? Yes No

Do you experience double vision? Yes No

I struggle with the following activities with or without glasses:

- Reading fine print Reading traffic signs Doing computer work
- Driving daytime Playing golf
- Watching TV Driving night/evening

I currently have problems with:

- Glare/Halos Blurred vision
- Hazy/Blurry vision Seeing in poor/dim lighting

My hobbies include:

- Crafts/Sewing/Painting Computer/Tablet Boating/Fishing
- Piano/Music Reading Swimming/Water Activities
- Sports Shooting/Hunting Golf

Fill in the circle on the scale below that would best describe your personality.



EASY GOING



PERFECTIONIST

COLLINS VISION

MEDICAL HISTORY / REVIEW OF SYSTEMS (Page 1 of 2)

NAME: _____ D.O.B. _____ DATE: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: None Latex Iodine Penicillin Codeine Sulfa
 Aspirin Other _____

Who is your primary care physician? Name: _____ Ph: _____

Who is your cardiologist? Name: _____ Ph: _____

Who is your pulmonologist? Name: _____ Ph: _____

Who is your endocrinologist? Name: _____ Ph: _____

REVIEW OF SYMPTOMS: (Please check any that may apply to you or symptoms you have.) OR I do not have any problems.

EYE HISTORY DIAGNOSIS

- ____ Cataracts
- ____ Glaucoma
- ____ Macular Degeneration
- ____ Retinal Disease
- ____ Amblyopia
- ____ Corneal Disease
- ____ Dry Eye Syndrome
- ____ Other: _____

SYSTEMIC INFECTIONS

- ____ Usual Childhood illness: Measles, Chickenpox, Mumps
- ____ HIV
- ____ Hepatitis
- ____ Herpes Virus
- ____ Meningitis
- ____ Shingles
- ____ TB
- ____ Other: _____

EYE SURGERIES: List all eye surgeries and performing doctor

SYSTEMIC ILLNESSES

- ____ Diabetes
- ____ High Blood Pressure
- ____ High Cholesterol
- ____ History of Stroke
- ____ Cancer
- ____ Heart Disease
- ____ Lung Disease
- ____ Environmental Allergies
- ____ Enlarged Prostate/Increase BPH
- ____ Thyroid Disease
- ____ Other: _____

HEAD / OCULAR TRAUMA: Please list below

GENERAL SURGERIES: Please list below

FAMILY HISTORY:

- Diabetes Yes No _____
- Macular Degeneration Yes No _____
- Glaucoma Yes No _____
- Eye disease Yes No _____

SOCIAL HISTORY:

- Do you smoke? Yes No How many packs per day? _____
- Do you drink alcohol? Yes No How many drinks per day? _____
- Do you use other recreational drugs? Yes No _____

Patient Signature / Representative Signature

Date

