Collins VISION

(239) 936-4706

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: _____

Do you wear contacts: ☐ Soft ☐ Toric ☐ RGP Yes ❑ No ❑

Do you have prism in your glasses? Yes ❑ No ❑ Do you have double vision? Yes ❑ No ❑

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?	YES	NO
1. Reading small print, such as labels on medicine bottles, telephone books, food labels, or reading a newspaper or book?	❑	❑
2. Reading a large-print book, or large-print newspaper, or large numbers on a telephone?	❑	❑
3. Recognizing people when they are close to you?	❑	❑
4. Seeing steps, stairs or curbs?	❑	❑
5. Reading traffic signs, street signs, or store signs?	❑	❑
6. Doing fine handiwork like sewing, knitting, crocheting or carpentry?	❑	❑
7. Writing checks or filling out forms?	❑	❑
8. Playing games such as bingo, dominos, or card games?	❑	❑
9. Taking part in sports like bowling, golf or tennis?	❑	❑
10. Cooking?	❑	❑
11. Watching television?	❑	❑
12. Seeing your smartphone or tablet?	❑	❑

SYMPTOMS

Have you been bothered by?	YES	NO
1. Poor Night Vision	❑	❑
2. Seeing Rings or halos around lights?	❑	❑
3. Glare caused by headlights, street lights, or bright sunlight?	❑	❑
4. Hazy and/or blurry vision?	❑	❑
5. Seeing well in poor or dim light?	❑	❑
6. Poor color vision / distinguishing colors?	❑	❑
7. Double vision?	❑	❑

DRIVING

Do you currently drive a car? ☐ YES (continue) ☐ NO (stop here)

	YES	NO
1. Do you have difficulty <u>driving during the day</u> because of your vision?	❑	❑
2. Do you have difficulty <u>driving at night</u> because of your vision?	❑	❑

Patient Signature: _____ **Date:** _____

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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

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PATIENT MEDICAL HISTORY FORM

NAME:_____**D.OB.**_____**DATE:**_____

PHARMACY:_____**LOCATION:**_____ **PH:**_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Medication Name	**Dose**	**Frequency**