(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: ______________

Present or past occupation: ______________________________

Have you previously been seen by Doctor: ☐ Collins ☐ Jones ☐ Rosen ☐ 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
☐ Driving daytime
☐ Watching TV
☐ Reading traffic signs
☐ Playing golf
☐ Driving night/evening
☐ Doing computer work

I currently have problems with:

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

My hobbies include:

☐ Crafts/Sewing/Painting
☐ Piano/Music
☐ Sports
☐ Computer/Tablet
☐ Reading
☐ Shooting/Hunting
☐ Boating/Fishing
☐ Swimming/Water Activities
☐ 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: _________________________

EYE SURGERIES: List all eye surgeries and performing doctor

____
____
____
____

HEAD / OCULAR TRAUMA: Please list below

____
____
____

SYSTEMIC INFECTIONS

____Usual Childhood illness: Measles, Chickenpox, Mumps
____HIV
____Hepatitis
____Herpes Virus
____Meningitis
____Shingles
____TB
____Other: ___________________________________

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:_____________________________________

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

COLLINS VISION

PATIENT MEDICAL HISTORY FORM

NAME:____**D.OB.**___________________**DATE:**____________________

PHARMACY:____**LOCATION:**______________ **PH:**_______________________

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