Collins VISION
Bringing Your World Into Focus

Date ____/____/____

Patient Medical History / Review of Systems

Name ______________________ ____ ______________________ Date of Birth ___/___/___ Age ______
First MI Last

Allergies ____

Smoking: ☐ YES ☐ NO If Yes: How much? __________ How Long? __________ When quit? __________
Alcohol: ☐ YES ☐ NO If Yes: How much? __________

Please list all surgeries or illnesses within the past 5 years: ____
____
____

Please list all medications you are currently taking: ____
____
____

Family History: Check all that apply and explain ____

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration	☐ Arthritis
☐ Cancer	☐ TB	☐ Cataracts	☐ Retinal Disease	☐ Lazy Eye
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure	

Review of Symptoms To the best of your ability, have you ever been treated or told you have?

Eyes	YES	NO
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Ear, Nose, Throat		
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Difficulty Lying Flat	☐	☐

Respiratory	YES	NO
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Gastrointestinal		
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐
Genito-urinary		
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
History Kidney Stones	☐	☐
History sexually transmitted disease	☐	☐
Psychiatric		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐

Blood/Lymph	YES	NO
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolonged Bleeding	☐	☐
Heavy Aspirin Usage	☐	☐
MusculoSkeletal		
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swelling	☐	☐
Skin		
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐
Neurological		
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐

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Patient/Guardian Signature