

# 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 \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

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.

## CONSTITUTIONAL

\_\_\_\_ Recent fevers/ sweats  
\_\_\_\_ Unexplained weight loss/gain  
\_\_\_\_ Unexplained fatigue/weakness

## EYE HISTORY

\_\_\_\_ Change in Vision  
\_\_\_\_ Double Vision  
\_\_\_\_ Dry eyes  
\_\_\_\_ Baggy Eyelids  
\_\_\_\_ Eye Pain/ Soreness  
\_\_\_\_ Eye Injury  
\_\_\_\_ Do you wear Contacts (Yes / No)  
\_\_\_\_ Other, Please Explain \_\_\_\_\_  
\_\_\_\_ Glaucoma / Retinal Disease (Circle)

## EARS/ NOSE/ THROAT/ MOUTH

\_\_\_\_ Difficulty hearing / ringing in ears  
\_\_\_\_ Hay Fever/ allergies  
\_\_\_\_ Trouble swallowing  
\_\_\_\_ Hearing Aids

## PULMONARY

\_\_\_\_ Chronic Cough  
\_\_\_\_ Asthma/ Wheezing  
\_\_\_\_ COPD / Shortness of Breath

## MUSCULOSKELETAL

\_\_\_\_ Jaw Pain  
\_\_\_\_ Joint Pain/ Swelling

## GASTROINTESTINAL

\_\_\_\_ Frequent Heart Burn  
\_\_\_\_ Indigestion  
\_\_\_\_ Frequent or severe vomiting  
\_\_\_\_ Frequent diarrhea

## SKIN

\_\_\_\_ Rash  
\_\_\_\_ Unusual moles  
\_\_\_\_ Skin Cancer BCC / SCC

## NEUROLOGICAL

\_\_\_\_ Headaches  
\_\_\_\_ Memory Loss  
\_\_\_\_ Fainting Spells  
\_\_\_\_ History of a Stroke / TIA  
\_\_\_\_ Seizures

## CARDIOVASCULAR

\_\_\_\_ Chest Pain/discomfort  
\_\_\_\_ Palpitations / Arrhythmia  
\_\_\_\_ Short of breath with exertion  
\_\_\_\_ Cardiac Stents / MI  
\_\_\_\_ CHF  
\_\_\_\_ Irregular Heart Beat

## HEMOTOLOGY

\_\_\_\_ Easy Bruising  
\_\_\_\_ Anemia  
\_\_\_\_ Blood disorders/clots  
\_\_\_\_ Enlarged lymph nodes

## PSYCHIATRIC

\_\_\_\_ Anxiety  
\_\_\_\_ Depression  
\_\_\_\_ Panic attacks  
\_\_\_\_ Bipolar disorder  
\_\_\_\_ Problems sleeping

## ENDOOCRINE

\_\_\_\_ Hypothyroid  
\_\_\_\_ Hyperthyroid  
\_\_\_\_ Diabetes, How long? \_\_\_\_\_  
Insulin Dependant. / Oral (Please circle)

## URINARY

\_\_\_\_ Frequent Urination / Blood in urine  
\_\_\_\_ Incontinence  
\_\_\_\_ Prostate / BPH

## ALLERGIC/ IMMUNOLOGIC /INFECTIONS

\_\_\_\_ Hepatitis A, B or C (Circle)  
\_\_\_\_ HIV  
\_\_\_\_ Lupus  
\_\_\_\_ Environmental allergies  
\_\_\_\_ Rheumatoid Arthritis  
\_\_\_\_ Fibromyalgia

## FEMALES

\_\_\_\_ Pregnant Yes or No  
\_\_\_\_ Number of live births

SURGICAL HISTORY: Please list all previous surgeries:

\_\_\_\_\_

Have you ever had any complications with anesthesia?  Yes  No

Do you have any artificial joints?  Yes  No

Do you have a defibrillator?  Yes  No

Do you have a pacemaker?  Yes  No

Please list: \_\_\_\_\_

Please list: \_\_\_\_\_

Please list: \_\_\_\_\_

Please list: \_\_\_\_\_

FAMILY HISTORY: Do you have a family history? :

Diabetes  Yes  No \_\_\_\_\_

Arthritis  Yes  No \_\_\_\_\_

Eye disease  Yes  No \_\_\_\_\_

Cataracts  Yes  No \_\_\_\_\_

Glaucoma  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

