COLLINS EYE CENTER

PATIENT FORM updated 11-15-23

GENERAL INFORMATION

SSN

Guarantor if other than Self

Cell Phone Work Phone Home Phone

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed

Reason for Visit:

Referring Provider

Pharmacy name and location Pharmacy phone

Primary Care Physician Office phone

Do you have any of the following conditions?

☐Cataract	☐Diabetic Retinopathy	☐Iritis or Uveitis
☐Age Related Macular Degeneration	☐Dry Eye	☐Retinal problems
☐Glaucoma	☐Corneal ulcer or eye inflammation	☐Eye Surgery
☐Diabetes	☐Floaters and/or flashes of light	☐Drug Allergies: List

Please list current medications and dosage or provide a copy(Include over the counter)

Please list any drug allergies:

Alcohol Use? ☐None ☐1-2/day ☐Social ☐ Above Average Use

Tobacco Use? ☐None ☐Former ☐ <1pk/day ☐1-2pk/day ☐>2pk/day

Smoking status? ☐Current ☐Former ☐Never

Have you had or experienced, or been treated for any of the following?

	You
AIDS/HIV	☐
Allergies	☐
Arthritis	☐
Asthma	☐
Blood/Lymph Disorder	☐
Cancer	☐
Diabetes Type 1	☐
Diabetes Type 2	☐
Ear, Nose, Throat conditions	☐
Gastrointestinal conditions	☐
Headaches, severe	☐
Heart Disease	☐
High Blood Pressure	☐
High Cholesterol	☐
Kidney Disease	☐
Lupus	☐
Neurological Conditions	☐
Psychiatric Disorder	☐
Seizures	☐
Skin Conditions List:_____	☐
Stroke	☐
Hyperthyroidism	☐
Hypothyroidism	☐