Eyecare SPECIALTIES

Dr. Michael Semmler
Dr. Susan Semmler
Dr. Amanda Moore
Optometrists

WELCOME TO OUR OFFICE

Today's Date_____

Our Mission
Caring for patients like family, using technology to provide outstanding eye care.

(PLEASE PRINT)

Name _____
Spouse or Parent/Guardian _____
Mailing Address _____
City, State, Zip _____
Date of Birth _____ Age _____ Sex: M F

Home Phone _____ Alt. Phone _____
Social Security # _____
Employer (or School) _____
Health Insurance: ☐Medicare ☐Medicaid
☐Other_____
Vision Insurance ☐VSP ☐Other_____
Ethnicity: White___African American___Hispanic__

The e-mail address listed below may be used to send a summary of your exam findings or communicate other health information. Please provide your e-mail address below if you *authorize* this form of communication.

E-mail address: _____

EYE HISTORY

Date of Last Eye Exam_____
Name of Last Eye Doctor _____
What is the major purpose of this visit? _____
_____
Do you wear glasses? ☐Yes ☐No
Do you wear contact lenses? ☐Yes ☐No
Do you have any problems with your present contact lenses or glasses? _____

Do you have problems with any of the following?

☐ Blurred vision	☐ Sandy /gritty sensation
☐ Distorted vision/halos	☐ Itching or burning
☐ Loss of side vision	☐ Excess Tearing
☐ Double Vision	☐ Light Sensitivity
☐ Dryness	☐ Eye pain or soreness
☐ Redness	☐ Flashes/floaters

Please indicate if **you** have or have had. . . .

☐ Crossed eyes	☐ Glaucoma
☐ Lazy eye	☐ Cataract
☐ Drooping eyelid	☐ Macular Degeneration
☐ Retinal Disease	☐ Eye Injury
☐ Eye /Lid Infections	☐ Eye Surgery

If yes to any of the above, please explain _____
_____
_____

VISUAL NEEDS

Do You..... (check the box if your answer is yes)

☐Work at a computer for long periods of time?
☐Have one pair of glasses?
☐Want information on thinner, lighter lenses?
☐Want information on lineless bifocals?
☐Spend a lot of time outdoors?
☐Ever find a need for prescription sunglasses?
☐Have problems with glare or reflections (ex: night driving)?
☐Participate in sport activities? _____
☐Wear or ever tried wearing contact lenses?

FAMILY EYE HISTORY

Relationship to you

☐Blindness _____
☐Glaucoma _____
☐Macular Degeneration _____
☐Other eye disease _____

How did you first hear about our office?
☐Yellow Pages ☐Newspaper ☐Village Greeters
☐Radio ☐Community Event
☐Friend/Relative... Who? _____
☐Physician... Who? _____

How will you settle your account today?
☐Check ☐Credit Card ☐Cash

Please complete page 2

MEDICAL HISTORY

Date of last physical: _____ Physician: _____

List major injuries and surgeries:

_____

_____

_____

History of any cancer? ☐ YES ☐ NO If yes, please give details: _____

_____

Female patients: Are you pregnant or nursing? ☐ YES ☐ NO

ALLERGIES TO MEDICATIONS? ☐ NONE KNOWN

☐ YES _____

MEDICATIONS AND SOCIAL HISTORY

This information is kept strictly confidential and is important for medical purposes as well as compliance with insurance directives.

LIST ALL MEDICATIONS or provide a list _____

_____

_____

_____

_____

Do you drive? ☐ YES ☐ NO

Tobacco use? ☐ YES ☐ NO Type/Amount _____

Alcohol use? ☐ YES ☐ NO How much daily _____

IF YOU CURRENTLY HAVE, OR ARE TAKING MEDICATION FOR ANY OF THE FOLLOWING, MARK THE "YES" BOX AND EXPLAIN BELOW:

	YES
ALLERGY	
Seasonal	☐
Specific irritants	☐
TO MEDICATIONS	☐
CARDIOVASCULAR	
Heart conditions	☐
High Cholesterol	☐
High Blood Pressure	☐
History of Stroke	☐
Other	☐
CONSTITUTIONAL	
Change in appetite	☐
Dizziness/Disorientation	☐
Fatigue/Weakness	☐
Weight Loss/Gain	☐
ENDOCRINE	
Diabetes	☐
Thyroid Condition	☐
Kidney Disease	☐
Gout	☐
Pituitary disorder	☐
Other	☐
GASTROINTESTINAL	
Liver Condition	☐
Inflammatory Bowels	☐
Stomach Condition	☐
Other	☐
GENITOURINARY	
Bladder conditions	☐
Kidney conditions	☐
Menopause	☐
Prostate Cancer	☐
Uterine Cancer	☐
Other	☐
HEAD (EARS, NOSE, MOUTH, THROAT)	
Dry Mouth	☐
Headaches (cluster/migraines)	☐
Meniere's Disease	☐
Ear Infections	☐
Sinus Condition	☐
Other	☐

	YES
HEMATOLOGIC/LYMPHATIC	
Anemia	☐
Breast Cancer	☐
Temporal Arteritis	☐
Other Blood Disorder	☐
IMMUNOLOGIC	
Decreased immunity	☐
Herpes Zoster ("shingles")	☐
Lyme Disease	☐
HIV/AIDS	☐
Other Immune disorder	☐
INTEGUMENTARY (SKIN)	
Acne/Rosacea	☐
Skin Cancer	☐
Dermatitis/Psoriasis	☐
Lupus	☐
Other Skin Condition	☐
MUSCULOSKELETAL	
Arthritis	☐
Osteoporosis	☐
Other skeletal disorder	☐
NEUROLOGICAL	
Brain tumor	☐
Brain damage or trauma	☐
Multiple Sclerosis	☐
Parkinson's Disease	☐
Nerve Palsy	☐
PSYCHIATRIC	
Anxiety/Depression	☐
Other	☐
RESPIRATORY	
Asthma	☐
Lung disease	☐
Emphysema	☐
COPD	☐

If you answered YES to any of the above, or have a condition not listed, please explain below:

_____

_____

_____

_____

Patient's Signature _____ Date: _____