Dr. Michael Semmler
Dr. Susan Semmler
Optometrists

WELCOME TO OUR OFFICE

OUR MISSION

Caring for patients like family and 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: _____

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 y our present contact lenses or glasses? _____

Do you have problems with any of the following?

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

Please indicate if you have or have had . . .

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

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

Visual Needs

- ☐ 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 ☐ News Paper ☐ 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? History of any cancer? ☐ YES ☐ NO If 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: _____