Welcome to Simmons Eye Care

Today's Date: _____
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Last: _____
First : _____ Middle Initial: ___
Preferred name/nickname: _____
DOB: _____ Age _____ Sex: M F
Social Security #: _____
☐ Married ☐ Divorced ☐ Single ☐ Minor
☐ Partnered ☐ Separated ☐ Widowed
Address: _____
City: _____ St. _____ Zip: _____
Home #: _____
Cell #: _____
Is text ok? ☐ Yes ☐ No
Email Address: _____
Occupation: _____
Employer: _____ Phone # _____
Spouse (Parent) _____ Phone # _____
Responsible Party _____ Phone # _____
Have we seen a member of your family? ☐ Yes ☐ No
Name: _____ Relation: _____
Name: _____ Relation: _____
Whom may we thank for referring you to our office?

_____

Medical History

Have you ever been diagnosed with the following?

Constitutional ☐ ☐
Fever Weight Loss/Gain N Y
Integumentary (skin) ☐N ☐Y
Neurological
Headaches ☐N ☐Y
Migraines ☐N ☐Y
Seizures ☐N ☐Y
Endocrine
Thyroid/Other Glands ☐N ☐Y
Rheumatoid Arthritis ☐N ☐Y
Anemia ☐N ☐Y
Kidney Disease ☐N ☐Y

Ear, Nose, Mouth, Throat
Allergies ☐N ☐Y
Sinus Congestion ☐N ☐Y
Runny Nose ☐N ☐Y
Chronic Cough ☐N ☐Y
Dry Throat/Mouth ☐N ☐Y
Respiratory ☐ ☐
Asthma N Y
Diabetes –Last A1C_____ N Y
High Blood Pressure ☐N ☐Y
Gastrointestinal Disease ☐N ☐Y

Family History

Is there a family history of any of the following? If yes, list the relationship.

☐N ☐Y Blindness _____
☐N ☐Y Cataracts _____
☐N ☐Y Corneal Problems _____
☐N ☐Y Glaucoma _____
☐N ☐Y Lazy Eye _____
☐N ☐Y Macular Degeneration _____
☐N ☐Y Retinal Problems _____
☐N ☐Y Diabetes _____
☐N ☐Y Heart Disease _____
☐N ☐Y Cancer _____
☐N ☐Y High Blood Pressure _____
☐N ☐Y Other _____

_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ☐N ☐Y
Do you use tobacco products? ☐N ☐Y
If yes, amount/how long? _____
Do you drink alcohol? ☐N ☐Y
If yes, amount/how long? _____
Do you use illegal drugs ☐N ☐Y
If yes, amount/how long? _____
Name of family physician: _____
Date of last visit: _____
Please list current medications (Rx or Over the counter)
_____
_____
_____
Please list any allergies to medication
_____
_____
List major injuries, surgeries, and/or hospitalizations you've had _____
_____
_____

Date of last exam: _____
Do you wear glasses? ☐ N ☐Y
If yes, how old is your current pair? _____
Do you wear contact lenses? _____
If no, are you interested in contact lenses? ☐ N ☐Y
If yes, what kind of contacts do you wear? _____
What brand of solution do you use? _____
Are you having problems with your current glasses or contacts? ☐N ☐Y
Are you interested in new glasses today? ☐ N ☐Y
Do you have more than one pair of prescription glasses ☐N ☐Y
Do you work at a computer ☐N ☐Y hours/week _____
Do you spend time outdoors ☐N ☐Y hours/week _____
Do you have prescription sunglasses? ☐ N ☐Y

Do you often experience……..

☐N ☐Y Blurry Vision
☐N ☐Y Burning
☐N ☐Y Double Vision
☐N ☐Y Flashes of Light
☐N ☐Y Floaters/Spots
☐N ☐Y Grittiness
☐N ☐Y Headaches
☐N ☐Y Itchy Eyes
☐N ☐Y Light Sensitivity
☐N ☐Y Red Eyes
☐N ☐Y Tearing
☐N ☐Y Difficulty Driving

Have you ever been diagnosed or treated for the following….

☐N ☐Y Cataracts
☐N ☐Y Corneal Abrasion
☐N ☐Y Eye Infection
☐N ☐Y Eye Injury
☐N ☐Y Glaucoma
☐N ☐Y Other:
☐N ☐Y Iritis
☐N ☐Y Lazy Eye
☐N ☐Y Macular Degeneration
☐N ☐Y Retinal Detachment

_____
_____