Welcome to Teague Eye & Vision Clinic

Vision Source

Dr. Randall Teague, O. D. * Dr. Creighton Simmons, O. D. * Dr. Shelby Brogdon, O. D.

Today's Date:_____

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.**

Last:_____

First:_____ **MI:**_____

DOB_____ **Age**_____ **Sex: M F**

Social Security #_____

☐ **Married** ☐ **Divorced** ☐ **Single** ☐ **Minor**

☐ **Partnered for**___**years** ☐ **Separated** ☐ **Widowed**

Address:_____

City_____**ST:**_____ **Zip:**_____

Home #_____**Cell #**_____

Is text ok? ☐ **Yes** ☐ **No**

Email Address_____

Employer_____**Phone#**_____

Spouse (Parent)_____**Phone #**_____

Have we seen a member of your family?_____

Name:_____**Relation**_____

Social History

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

Do you drive? **N Y**

Do you use tobacco? **N Y** If so 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? _____

_____

Family physician:_____

Current Medications_____

_____

Allergies to medication_____

Major injuries, surgeries, and/or hospitalizations:_____

_____

_____

_____

_____

Date of last eye exam:_____

Medical History

Have you ever been diagnosed with the following?

Constitutional

N Y Fever Weight gain/ loss
N Y Integumentary (skin)

Neurological

N Y Headaches
N Y Migraines
N Y Seizures

Endocrine

N Y Thyroid/ Other glands
N Y Rheumatoid Arthritis
N Y Anemia
N Y Kidney Disease
Disease
N Y Psychiatric

Ear, Nose, Mouth, Throat

N Y Allergies
N Y Sinus Congestion
N Y Runny Nose
N Y Chronic Cough
N Y Dry Throat/Mouth

RespiratoRy

N Y Asthma
N Y Emphysema
N Y Diabetes
N Y High Pressure
N Y Gastrointestinal

Do you wear glasses **N Y**

Are you interested in new glasses today? **N Y**

If yes, how old is your most recent pair**?**_____

Do you wear contacts**?** **N Y**

If yes, what brand? _____

If no are you interested in contact lenses? **N Y**

What solution do you use?_____

Do you have more than one pair of glasses? **N Y**

Do you work on a computer? **N Y**

Hours/week? _____

Do you spend time outside? **N Y**

Do you have prescription sunglasses? **N Y**

Family History

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

N Y Blindness _____
N Y Retinal Problems _____
N Y Cataracts _____
N Y Diabetes _____
N Y Corneal Problems _____
N Y Heart disease _____
N Y Glaucoma _____
N Y Cancer _____
N Y Lazy Eye _____
N Y High Blood Pressure_____
N Y Macular Degeneration_____
N Y Other _____

Turn over

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 Iritis
N Y Lazy Eye
N Y Macular Degeneration
N Y Retinal Detachment
N Y Other_____

Thank you

Vision Source

ACKNOWLEDGEMENT

OF

NOTICE OF PRIVACY PRACTICES

The law requires that Teague Eye & Vision Clinic make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ **I have read or had explained to me Teague Eye & Vision Clinic's notice of privacy practice and agree to continue my care with Teague Eye & Vision Clinic under said terms.**
- ☐ **I was given the opportunity to read Teague Eye & Vision Clinic's Notice Privacy Practices and declined but wish to continue my care with Teague Eye & Vision Clinic under the terms of Teague Eye & Vision Clinic's privacy policies.**
- ☐ **I have read or had explained to me Teague Eye & Vision Clinic's Notice of Privacy Practice and do not wish to continue my care with Teague Eye & Vision Clinic under said terms.**
- ☐ **The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason as described as _____**

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient_____Date_____

I authorize _____ to have access to my records.

(SPOUSE) (PARENT) (PARTNER)

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative_____

Relation to Patient_____ Date_____

Turn over