Welcome to Simmons Eye Care

Vision Source

Dr. Creighton Simmons, 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 **Ear, Nose, Mouth, Throat**

N Y Fever Weight gain/ loss **N Y** Allergies

N Y Integumentary (skin) **N Y** Sinus Congestion

Neurological **N Y** Runny Nose

N Y Headaches **N Y** Chronic Cough

N Y Migraines **N Y** Dry Throat/Mouth

N Y Seizures **RespiratoRy**

Endocrine **N Y** Asthma

N Y Thyroid/ Other glands **N Y** Emphysema

N Y Rheumatoid Arthritis **N Y** Diabetes

N Y Anemia **N Y** High Pressure

N Y Kidney Disease **N Y** Gastrointestinal Disease

N Y Psychiatric

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** Headaches

N Y Burning **N Y** Itchy Eyes

N Y Double Vision **N Y** Light Sensitivity

N Y Flashes of light **N Y** Red Eyes

N Y Floaters/Spots **N Y** Tearing

N Y Grittiness **N Y** Difficulty Driving

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

N Y Cataracts **N Y** Iritis

N Y Corneal Abrasion **N Y** Lazy Eye

N Y Eye Infection **N Y** MacularDegeneration

N Y Eye Injury **N Y** Retinal Detachment

N Y Glaucoma **N Y** Other_____________

Thank you

Vision Source

ACKNOWLEDGEMENT

OF

NOTICE OF PRIVACY PRACTICES

The law requires that Simmons Eye Care 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 Simmons Eye Care's notice of privacy practice and agree to continue my care with Simmons Eye Care under said terms.**
- ☐ **I was given the opportunity to read Simmons Eye Care's Notice Privacy Practices and declined but wish to continue my care with Simmons Eye Care under the terms of Simmons Eye Care privacy policies.**
- ☐ **I have read or had explained to me Simmons Eye Care's Notice of Privacy Practice and do not wish to continue my care with Simmons Eye Care 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.

Signature____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