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102 Plaza Carmona Place Hot Springs Village (501) 922-5778
Dr. Michael Semmler
Dr. Susan Semmler
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 _____
Preferred Name _____
Spouse or Parent/Guardian _____
Mailing Address _____
City, State, Zip _____
Date of Birth _____ Age _____ Sex: M F
Daytime Ph# _____ Alt.

Social Security # _____
Employer (or School)
Health Insurance: ☐ Medicare ☐ Medicaid
☐ Other _____
Vision Insurance ☐ VSP ☐ Other _____
Ethnicity: White ☐ African American ☐ Hispanic ☐
Asian ☐ Pacific Islander ☐ Other

The e-mail address listed below may be used to send appointment reminders, a summary of your exam findings and 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?

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?

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

FAMILY EYE HISTORY

Relationship to you

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

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 _____

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

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

Please complete page 2

Medical History

Date of last physical? _____

Name of Physician: _____

List major injuries and surgeries: _____

History of cancer? ☐ Yes ☐ No

Female patients: Are you pregnant or nursing? Ye☐o ☐

ALLERGIES TO MEDICATIONS? ☐ None Known

if YES, please list _____

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 ☐ Yes ☐ No How Much daily?

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

	YES
ALLERGY	
Seasonal	☐
Specific irritants	☐
TO MEDICATIONS	☐
CARDIOVASCULAR	
Heart conditions	☐
High Cholesterol	☐
High Blood Pressure	☐
History of Stroke	☐
CONSTITUTIONAL	
change in appetite	☐
dizziness/disorientation	☐
fatigue/weakness	☐
weight loss/gain	☐
ENDOCRINE	
Diabetes	☐
Thyroid condition	☐
Kidney Disease	☐
Gout	☐
Pituitary disorder	☐
Gastrointestinal	
Liver Condition	☐
Inflammatory Bowels	☐
Stomach Condition	☐
GENITOURINARY	
Bladder conditions	☐
Kidney condition	☐
Menopause	☐
Prostate Cancer	☐
Uterine Cancer	☐
HEAD(EARS,NOSE, MOUTH,THROAT)	
Dry Mouth	☐
Headaches/cluster migraines	☐
Meniere's Disease	☐
Ear infections	☐
Sinus Conditions	☐

	YES
HEMATOLOGY/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 or damage	☐
Multiple Sclerosis	☐
Parkinson's Disease	☐
Nerve Palsy	☐
Dementia	☐
PSYCHIATRIC	
Anxiety/Depression	☐
Other	☐
RESPIRATORY	
Asthma	☐
Lung disease	☐
Emphysema COPD	☐
Sleep Apnea	☐

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

_____

_____

Patient's Signature _____ Date: _____

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