ALAMO Optometry

Gregory Kraskowsky, O.D.

Family Vision Care · Designer Eyewear

PERSONAL INFORMATION

Today's Date: _____

Legal Name: _____ Preferred Name/Nickname: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Date of Birth: _____ Email: _____

Date of Last Eye Exam: _____ By Whom? _____

Employer or School: _____ Occupation: _____

What is the major purpose of this visit? _____

Are you planning on getting glasses and/or contacts today? _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____*

INSURANCE INFORMATION

Vision Insurance: _____

Policy #: _____

Subscriber Name: _____

Subscriber SS#: _____

Subscriber Birth Date: _____

Medical Insurance: _____

Policy #: _____

Subscriber Name: _____

Subscriber SS#: _____

Subscriber Birth Date: _____

MEDICAL INFORMATION

Do you have problems with any of these systems?

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (Glands)	Yes/No	Diabetes	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No	Mental	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic	Yes/No	Skin	Yes/No
Respiratory	Yes/No	Headaches	Yes/No	High Blood Pressure	Yes/No		

Allergies to Medication Yes/No Which? _____

Current Medications: _____

Name of Family Doctor: _____ Date of Last Visit: _____

PERSONAL EYE HISTORY

Have you had any eye operations? Yes/No What kind? _____ Date: _____

Have you had any eye injury? Yes/No What kind? _____ Date: _____

Have you ever been treated or diagnosed with any of the following:

Cataracts	Yes/No	Glaucoma	Yes/No	Macular Degeneration	Yes/No
Lazy Eye	Yes/No	Dry Eyes	Yes/No	Retinal Detachment	Yes/No
Crossed Eyes	Yes/No	Eye Infections	Yes/No	Flashes/Floaters	Yes/No

LIFESTYLE QUESTIONS

Do you wear glasses? Yes/No Contact Lenses? Yes/No Type: _____

Do you have more than 1 pair of current prescription glasses? Yes/No

Do you have prescription sunglasses? Yes/No

Do you work at a computer? Yes/No

Do you have children or family members in need of eyecare? Yes/No

Do you want information on Laser Vision Correction? Yes/No

Do you prefer not to wear your glasses at times? Yes/No

Do you spend time outdoors? Yes/No

FAMILY HISTORY

High Blood Pressure	Yes/No	Relation:_____	Macular Degeneration	Yes/No	Relation:_____
Diabetes	Yes/No	Relation: _____	Retinal Detachment	Yes/No	Relation:_____
Glaucoma	Yes/No	Relation:_____	Cataracts	Yes/No	Relation:_____