A L A M O Optometry

Gregory Kraskowsky, O.D.

Family Vision Care · Designer Eyewear

PERSONAL INFORMATION

Today's Date: ______________________
Name: ________________________________
Address: __________________________________ City: _______________ State: ______ Zip:__________
Home Phone: ______________________ Cell 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: _________________________ Medical Insurance: __________________________
Subscriber Name: _________________________ Subscriber Name: ____________________________
Subscriber SS#: __________________________ Subscriber SS#: ______________________________
Subscriber Birth Date: ____________________ 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:______________

PATIENT USE

Initials: __________ Date:______________
Initials: __________ Date:______________
Initials:___________ Date:______________

DOCTOR USE

Initials:______________ Date:______________
Initials:______________ Date:______________
Initials:______________ Date:______________