

ALAMO Optometry

Gregory Kraskowsky, O.D.

Family Vision Care · Designer Eyewear

PERSONAL INFORMATION

Today's Date: _____
Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home 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: _____ 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: _____
Initials: _____ Date: _____

DOCTOR USE

Initials: _____ Date: _____
Initials: _____ Date: _____
Initials: _____ Date: _____
Initials: _____ Date: _____