

Krall Eye Clinic

General Information

Date: ____/____/____

Last Name _____ First Name: _____ M _____ DOB: ____/____/____
M or F _____ SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced / Widowed
Address: _____ City: _____ State: _____ Zip: _____
Home Ph: () _____ Work Ph: () _____ Cell Ph: () _____
Employer/School: _____ Occupation/School Grade: _____
E-mail Address: _____ Sports/Hobbies: _____
Emergency Contact: _____ Relation: _____ Phone #: () _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: ____/____/____ Primary Physician/Clinic: _____

Date of Last Eye Exam: ____/____/____ Clinic/Eye Doctor's Name: _____

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type: _____ Solution Used: _____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Have you ever had eye injuries? Yes No Which Eye? _____

Have you ever had eye surgeries? Yes No Why? _____

Have you used eye medication? Yes No Why? _____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed? _____

Glaucoma: Yes/No When were you diagnosed? _____

Macular Degeneration: Yes/No When were you diagnosed? _____

What are your visual symptoms: Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

[] Blurred Vision/Distance	R L B	[] Dry Eyes	R L B	[] Headaches	R L B
[] Blurred Vision/Near	R L B	[] Red Eyes	R L B	[] Migraine Headaches	R L B
[] Double Vision	R L B	[] Watery Eyes	R L B	[] Loss of Vision	R L B
[] Eye Strain	R L B	[] Wandering eye	R L B	[] Crossed Eyes	R L B
[] Eye Infections	R L B	[] Mucus Discharge	R L B	[] Light Sensitive	R L B
[] Eye Pain/Soreness	R L B	[] Floaters or Spots	R L B	[] Sandy/Gritty Feeling	R L B
[] Tired eyes	R L B	[] See Flashes	R L B	[] Poor Color Vision	R L B
[] Burning Eyes	R L B	[] See Halos	R L B	[] Droopy Lid	R L B
[] Itchy Eyes	R L B	[] Poor Night Vision	R L B		

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: __ None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other:	Endocrine: __ None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	Respiratory: __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
Constitutional: __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	Ocular __ None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	Psychiatric: __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
Neurological: __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	Musculoskeletal: __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	Immunologic: __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
Hematological: __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	Gastrointestinal __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	Ear/Nose/Throat: __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
Dermatologic: __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	Allergies (please list) __ None Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list physical reaction's to above allergies: _____

Please list any medications and/or drugs that you are taking (including herbal) : _____ See Attached List: _____

1	For	6	For
2	For	7	For
3	For	8	For
4	For	9	For
5	For	10	For

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION

Retinal Detachment: Yes/No _____	Blindness: Yes/No _____
High Blood Pressure: Yes/No _____	Cataracts: Yes/No _____
Diabetes: Yes/No _____	Glaucoma: Yes/No _____
Cancer: Yes/No _____	Crossed Eyes: Yes/No _____
Heart Disease: Yes/No _____	Macular Degeneratiom Yes/No _____
Thyroid Disease: Yes/No _____	Lupus Yes/No _____

Reviewed by:

Dr _____ Date _____