KRALL

EYE CLINIC

Setting standards for over 100 years

CASE HISTORY / REASON FOR VISIT:

Date _____/_____/_____

First_____ **M.I.**_____ **Last**_____

Address: _____

City:_____State:_____Zip: _____

Hm Ph:_____Work:_____Cell:_____

E-mail:_____

May we text or e-mail you when your glasses are ready? ☐ Yes ☐ No

Preferred method to contact you: ☐ Call ☐ Text ☐ E-mail

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed

DOB: _____ /_____ /_____ SSN: _____ /_____ /_____

Spouse Name:_____

Parent's Names (if child):_____

Do you have Insurance? ☐ Yes ☐ No

Primary Card Holder:_____ DOB: ___ /___ /___

Relationship:_____

Card Holder's Employer:_____

Employer's Phone Number:_____

Date of Last Medical Exam:_____ /_____ /_____

Date of Last Eye Exam:_____ /_____ /_____

Clinic/Eye Doctor's Name:_____

Primary Physician/Clinic:_____

Do you wear glasses? ☐ No ☐ All the time ☐ Sometimes

How old are your present glasses? _____

Do you wear prescription sun wear? ☐ Yes ☐ No

Any eye surgeries/injuries? ☐ Yes ☐ No If yes, explain:_____

_____

Do you use eye drops? ☐ Yes ☐ No Why?_____

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

Have you ever been diagnosed with?

Cataracts: ☐ Yes ☐ No When?_____

Glaucoma: ☐ Yes ☐ No When?_____

Macular Degeneration: ☐ Yes ☐ No When?_____

Other Information:

MEDICATION: Are you currently taking any medications? If yes, please list:

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

for _____

Todays Date _____/_____/_____

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, IF YOU HAVE NONE OF THESE CONDITIONS…PLEASE CHECK NONE.

Cardiovascular: ☐ **None** ☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ Vascular Disease ☐ Other:	**Endocrine:** ☐ **None** ☐ Non-Insulin Dependent Diabetes ☐ Insulin Dependent Diabetes ☐ Thyroid Problem ☐ Hormonal Dysfunction ☐ Other:	**Respiratory:** ☐ **None** ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other:
Constitutional: ☐ **None** ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other:	**Ocular** ☐ **None** ☐ Glaucoma ☐ Macular Degeneration ☐ Detached Retina ☐ Other:	**Psychiatric:** ☐ **None** ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other:
Neurological: ☐ **None** ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other:	**Musculoskeletal:** ☐ **None** ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Other:	**Immunologic:** ☐ **None** ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other:
Hematological: ☐ **None** ☐ Anemia ☐ Leukemia ☐ Other:	**Gastrointestinal** ☐ **None** ☐ Crohn's ☐ Colitis ☐ Other:	**Ear/Nose/Throat:** ☐ **None** ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other:
Dermatologic: ☐ **None** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ 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: _____

_____

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 Degeneratio	Yes/No	_____
Thyroid Disease:	Yes/No	_____	Lupus	Yes/No	_____

Other : _____

_____

_____

Reviewed by:

Dr _____ Date _____