KRATES
EYE
CENTERS

Medical, Laser and Surgical Eye Care

Board Certified Eye Care Specialists

Welcome to Our Office

NAME_____ Date of Birth_____

Address_____ Social Security#_____

City/State/Zip_____ Telephone_____

E-mail_____ Cell Telephone_____

Spouse's Name_____ Spouse's Date of Birth_____

Name of person responsible for this account_____

Address_____ Home Telephone No._____

Date of Birth_____ Relationship to Patient_____

Primary Insurance_____

Secondary Insurance_____

Is this visit Work Related:_____

Family Physician Name & Telephone No._____

Who referred you to our office:_____

Emergency Contact Person_____ Telephone_____

ON MY BEHALF, YOU MAY RELEASE MY MEDICAL CARE INFORMTION TO:

Name_____ Relationship_____

Name_____ Relationship_____

I acknowledge that Krates Eye Centers follows the HIPPA Privacy Policies. A copy of the notice is available from the receptionist. I authorize release of any privacy information concerning my health care, advice and treatment provided for the purpose of evaluating and administering care and/or claims of insurance and government issued benefits. I also hereby authorized payment of insurance benefits otherwise payable to me, directly to the doctor.

Signed:_____ Date:_____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____

Referring /Specialty Dr._____

Pharmacy:_____

Location(street & city) _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ French ☐ Italian ☐ Japanese
☐ Portuguese ☐ Russian ☐ Spanish

Allergies: Reaction Severity

_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

☐ Overall Healthy
☐ Amblyopia (Lazy eye)
☐ Aphakia
☐ Astigmatism
☐ Cataracts
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Glaucoma
☐ Hyperopia (Far sighted)
☐ Iritis
☐ Keratoconus
☐ Macular Degeneration
☐ Myopia (Near sighted)
☐ Optic Neuritis
☐ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply)

☐ No prior ocular surgery
☐ Blepharoplasty
☐ Cataract Surgery
☐ Corneal Transplant
☐ Foreign Body Removal
☐ Retinal Laser Surgery
☐ LASIK
☐ PRK (eye muscle surgery)
☐ Punctal Plugs
☐ RK
☐ Strabismus Surgery
☐ Trabeculectomy (Glaucoma surgery)
☐ Vitrectomy

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

☐ Overall Healthy
☐ AIDS
☐ Diabetes
☐ Rheumatoid Arthritis
☐ Herpes
☐ HIV Positive
☐ Hypertension
☐ Hypothyroidism
☐ Lupus
☐ Multiple Sclerosis
☐ Sjogrens
☐ Graves Disease
☐ Hyperthyroidism

Other_____

Current Eye Medications: (Please list)

_____
_____
_____

Systemic Illnesses:

- ☐ No history of Illnesses
- ☐ Anemia
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Migraine
- ☐ Polymyalgia
- ☐ Psychiatric Disorder
- ☐ Skin Cancer
- ☐ Stroke

Other_____

General Surgeries / Operations: (Please list)

_____

_____

_____

Current Other Medications(Pills, inhalers, injections): (Please list)

_____

_____

_____

Family History:

- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Stroke
- ☐ TB

Other_____

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker

☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often?_____

Drug Use: ☐ Yes ☐ No If yes what and how often?_____