KRATES EYE CENTERS

Welcome to Our Office

NAME_____Date of Birth_____

Address_____Social Security#_____

City/State/Zip_____Telephone_____

E-mail_____Cell Telephone_____

Please circle one Preferred Method of Contact: Home Phone Cell Phone E-mail Regular Mail

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:_____

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
□ Myopia (Near sighted)
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Optic Neuritis
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty (Eyelid surgery)
□ Cataract Surgery
□ Corneal Transplant
□ Vitrectomy
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Eye Muscle Surgery

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens Disease
□ 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)

NAME STRENGTH (% or mg) HOW OFTEN

_____

_____

_____

_____

_____

Family History: M=mother, F=father, B=brother, S=sister, GM=grandmother, GF=grandfather

□ 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?_____

THIS INFORMATION IS REQUIRED IN ORDER FOR OUR OFFICE TO BE IN COMPLIANCE WITH THE NEW FEDERAL HEALTH AND INFORMATION GUIDELINES EFFECTIVE JANUARY, 2014.