WELCOME TO DR. KRACHER'S OFFICE

DATE: ____/___/___

NAME_____SS #_____
(Last) (First) (MI)

ADDRESS_____CITY_____ST._____ZIP____

AGE_____SEX: M F DATE OF BIRTH____/____/____HOME PHONE_____
EMAIL: _____
DATE OF LAST EYE EXAM____/____/____
EMPLOYER_____OCCUPATION_____
BUSINESS PHONE _____

METHOD OF PAYMENT: Check___Cash___Visa___Mastercard___American Express___

DO YOU FEEL A CHANGE IN YOUR PRESCRIPTION IS NEEDED TO SEE CLEARLY? YES NO
HAVE YOU EVER WORN CONTACT LENSES? YES___ NO ___
DO YOU WEAR CONTACT LENSES NOW? YES ___ NO ___
TYPE OF LENSES? _____BRAND_____
WHAT PROMPTED THIS APPOINTMENT? _____
WHO REFERRED YOU? _____
ARE YOU PLANNING TO GET NEW GLASSES TODAY? YES NO ONLY IF RX CHANGES.

ARE YOU PLANNING TO GET NEW CONTACTS TODAY? YES NO ONLY IF RX CHANGES

ARE YOU INTERESTED IN FINDING OUT MORE ABOUT LASER VISION CORRECTION? YES NO MAYBE

PAST OCULAR HISTORY:

Have you had:

1. Laser to either eye? Y N
2. Surgery to either eye? Y N
3. Injury to either eye? Y N

PAST MEDICAL HISTORY:

Do you or have you previously had:

1. Heart Disease? Y N
2. High blood pressure? Y N
3. A stroke? Y N
4. Diabetes? Y N
5. Breathing problems? Y N
6. Liver or kidney disease? Y N
7. Hepatitis? Y N
8. Stomach/intestinal problems? Y N
9. Cancer? Y N
10. Bleeding disorder? Y N
11. Arthritis? Y N
12. Other medical problems? Y N

ALLERGIES:

13. Hay fever? Y N
14. Eyedrops/other medications? Y N
15. Oral medications? Y N

SURGERY:

16. Any surgery other than eyes? Y N
17. Reaction to anesthesia ? Y N

MEDICINES: Do you currently take

18. Eyedrops? Y N
19. Aspirin or related compounds? Y N
20. Prescription medication? Y N
21. Other medicines (vitamins,etc.) Y N

FAMILY HISTORY:

22. Cataract in family? Y N
23. Glaucoma in family? Y N
24. Macular degeneration in family? Y N
25. Diabetes in family? Y N
26. Other health problems? Y N

Reviewed by Dr. Kracher_____ Date_____