DEBRA KROLL M.D.
Oculofacial Plastic Surgery

Demographic information & Medical History Form

Name:_____Today's Date:_____
Address:_____
City/State/Zip:_____
Phone:_____home|_____work|_____cell
Email:_____
Date of Birth:_____ age: _____
Social Security Number:_____
Health Insurance and Member Number:_____
Insurance Subscriber (Name and DOB):_____
Emergency Contact Information:_____

Primary Care Physician and address:_____
Referring Physician and address:_____
Pharmacy address and phone number:_____

What is the reason for today's visit?_____

What health problems do you have?_____
What medications do you take?_____
Have you had eye problems or surgery?_____
Which eye drops do you take?_____
Any family history of eye problems or skin cancer?_____
Married/Single/live alone (please circle)_____
Any Tobacco/Alcohol/Drug Use? (please circle)_____
Occupation:_____
Do you have medication allergies?_____

_____

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Review of systems: Do you have any of the following? Please fill in details as needed

Fevers/chills/night sweats?	No	Yes
Headaches/dizziness?	No	Yes
Ringing/whooshing in ears?	No	Yes
Chest pain/palpitations/irregular heartbeat?	No	Yes
Shortness of breath/cough?	No	Yes
Urinary/kidney/genital problems?	No	Yes
Muscle aches/weakness/arthritis?	No	Yes
Numbness/tingling?	No	Yes
Rashes/itching of the skin/easy bruising/poor wound healing?	No	Yes
Psychiatric/memory problems?	No	Yes

Please explain any of the above:

_____

_____

Do you wish to discuss aesthetics? Yes No

Eyelid bags	Non surgical eyelift	Botox/Dysport
Eyelid drooping	Lip Augmentation	Pelleve
Wrinkles	Unsightly scarring	Microneedling
Smile lines	Cheek Augmentation	Skin Peels
Eye brow droop	Fractionated Laser	Skin Care

This area for internal use only:

I have reviewed this document:

Debra M. Kroll, M.D. **Date**