KALAMAZOO OPTOMETRY

NEW PATIENT INFORMATION FORM

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Dr. James Adams, OD
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PATIENT INFORMATION

First Name	Middle Name	Last Name	Date of Birth	Gender
Home Address				Ethnicity
City	State	Zip	Home Phone	Cell Phone
If under 18, name of parents or guardian		Name of spouse		
Occupation or school grade	Employer or school		Email address	Work Phone
Social Security Number	Primary Insurance Company	Policy #	Secondary Insurance Company	Policy #

PATIENT HEALTH HISTORY

Do you currently wear: ❑Glasses ❑Contacts		Reason for today's visit:	
Current Family Doctor	Last visit when and why?	Previous Eyecare Provider	Last visit when and why?

Constitution	❑Fever ❑Sudden Weight Loss ❑Sudden Weight Gain ❑Fatigue ❑Insomnia	
Cardiovascular	❑Heart Disease ❑High Blood Pressure ❑Stroke ❑High Cholesterol ❑Irregular Heartbeat	
Ear, Nose, Throat	❑Hearing loss ❑Nose Bleeds ❑Sore Throat ❑Sinusitis ❑Chronic Colds ❑Mouth Sores	
Respiratory	❑Asthma ❑COPD ❑Emphysema ❑Shortness of Breath ❑Bronchitis ❑Sleep Apnea	
Gastrointestinal	❑Constipation ❑Diarrhea ❑Ulcers ❑Heartburn	
Genitourinary	❑Frequent Urination ❑Incontinence ❑Bladder Infections ❑Dialysis	
Musculoskeletal	❑ Joint/Muscle Pain ❑Arthritis ❑Multiple Sclerosis	
Integumentary	❑Dermatitis ❑Dryness ❑Eczema ❑Psoriasis ❑Rosacea	
Neurological	❑ Epilepsy ❑Headaches ❑Migraines ❑Seizures ❑Bells Palsy	
Psychiatric	❑Nervousness ❑Depression ❑Confusion ❑Mood Swings	
Endocrine	❑Hypothyroid ❑Hyperthyroid ❑Diabetes (❑Type 1 ❑Type 2)	
Hematologic/Lymphatic	❑Anemia ❑Bleeding Disorders ❑Lyme Disease ❑Leukemia ❑Sickle Cell	
Allergy/Immunologic	❑Seasonal Allergies ❑Redness ❑Itching ❑HIV	
Females are you:	❑Pregnant ❑Nursing	Cancer ❑Y ❑N Type _____
Computer Use	❑Yes ❑No How many hours _____	
Ocular Health	❑Glaucoma ❑Cataracts ❑Macular Degeneration ❑Eye Injury ❑Retinal Disease ❑Other Disease ❑Blindness ❑Lazy Eye (Strabismus) ❑Amblyopia ❑Diabetic Retinopathy ❑Dry Eye ❑Eye Surgery ❑Flashes/Floaters in Vision ❑Glare/Light Sensitivity ❑Excessive Tearing/Watering ❑Burning ❑Other:	
Substance Use	Alcohol ❑Yes _____drinks/week ❑No	Drugs ❑Yes _____times/week ❑No
	Tobacco ❑Yes _____packs/day ❑No	
Hobbies	❑Fishing ❑Golfing ❑Reading ❑Sewing ❑Music ❑Sports ❑Other:	

FAMILY HEALTH HISTORY

Glaucoma	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Cataracts	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Macular Degeneration	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Eye Injury	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Retinal Disease	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Other Disease	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Blindness	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Strabismus (eye turn)	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Amblyopia (weak eye)	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Diabetes	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Cancer	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Heart Disease	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Hypertension	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Cholesterol	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Kidney Disease	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Stroke	❑Yes	❑No	❑Unknown	If yes: ❑Mother	❑Father	❑Sibling	❑Grandparent
Other							

MEDICATIONS

Please list all medications, including over-the-counter medications, and any eye drops.

Allergies

Please list all allergies, including allergies to medications, food, environment etc.

Do the allergies affect your eyes? ❑Yes ❑No