KALAMAZOO OPHTHALMOLOGY, P.C.
NEW PATIENT HISTORY FORM
(CONFIDENTIAL)

The doctors of Kalamazoo Ophthalmology appreciate your help in gathering this information. We are required to have this information in your chart to meet certain insurance requirements.

Name_____ Exam Date_____
Birthdate_____ Occupation_____ ☐ Retired
Preferred Pharmacy_____ Primary Physician_____

MEDICAL CONDITIONS – Please check if any you have or have had in the past ☐ **NONE**

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
  - ☐ Degenerative
  - ☐ Rheumatoid
- ☐ Asthma
- ☐ Cancer
  Type_____
- ☐ Cataracts
- ☐ Diabetes
  ____ Diabetes Type 1
  ____ Diabetes Type 2
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ MRSA
- ☐ Other (detail please)_____
- ☐ Multiple Sclerosis
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers

HOSPITAL ADMISSIONS ☐ **NONE**

Year	Illness or Operation	Year	Illness or Operation

MEDICATIONS (including over the counter and vitamins) ☐ **NONE** ☐ **SEE ATTACHED LIST**

Medication	Dosage	Medication	Dosage

ALLERGIES - List all allergies and reaction please ☐ **NONE KNOWN**

Allergy	Reaction	Allergy	Reaction

FAMILY HISTORY – please check the appropriate line and indicate which relative ☐ **NONE KNOWN**

- _____ Adopted
- _____ Cancer
- _____ Cataracts
- _____ Diabetes
- _____ Eye Muscle Problem
- _____ Glaucoma
- _____ Heart Attack
- _____ Heart Disease
- _____ Hypertension
- _____ Macular Degeneration
- _____ Retinal Problems
- _____ Stroke
- _____ Other

HEALTH HABITS – please check which of the substances you use and describe how much

- ☐ Caffeine (Coffee, Tea, Soda Pop) _____
- ☐ Tobacco_____ Type _____ How long? _____
- ☐ Drugs _____
- ☐ Alcohol _____

CURRENT MEDICAL HISTORY – please check if any apply ☐ NONE

ALLERGIC / IMMUNO
- ☐ Environmental Allergies _____
- ☐ Food Allergies _____

CARDIOVASCULAR
- ☐ Chest Pressure
- ☐ Chest Discomfort
- ☐ Irregular Heartbeat

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Abnormal Thirst
- ☐ Excessive Appetite

ENMT
- ☐ Hearing Loss

GASTROINTESTINAL
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting

URINARY
- ☐ Urination Problems
- ☐ Blood in Urine
- ☐ Excessive Urination
- ☐ Hx of Flomax Use

HEMATOLOGIC
- ☐ Bruise Easily
- ☐ Bleeding Disorder

SKIN
- ☐ Rash

MUSCULO/SKELETAL
- ☐ Arthritis
- ☐ Joint Swelling
- ☐ Muscle Weakness

NEUROLOGICAL
- ☐ Dizziness
- ☐ Gait Disturbance
- ☐ Headache

PSYCHIATRIC
- ☐ Emotional Changes

RESPIRATORY
- ☐ Cough
- ☐ Wheeziness

WOMEN ONLY

Are you pregnant? Y / N

Number of Children_____

OTHER

Are you currently under Hospice Care? Y / N

Have you ever been diagnosed with MRSA? Y / N

Have you had 2 or more falls in the past year or any fall with injury in the in the last year? Y / N

Details of above conditions noted:_____

_____

_____

_____

_____

If you have any questions about this form, or there is other information which you feel might be important, please discuss it with the doctor.

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

_____ _____

Reviewed by Date

_____ _____

Physician Signature Date