



CHAD M. KRESNAK, OD
AUTUMN KILLOP, OD, MPH, FAAO
LILLIAN KALACZINSKI, OD, MPH, FAAO
JACQUELYN COSGROVE, OD, FAAO

2820 EAST BELTLINE LANE NE
 GRAND RAPIDS, MICHIGAN 49525
 TELEPHONE (616) 363-5413
 FAX (616) 363-4211
 www.grandrapidseyecare.com

MEMBERS AMERICAN OPTOMETRIC ASSOCIATION

Name: Last: _____ First: _____

Address: _____ DOB: ___/___/___ Gender: _____

City: _____, State: ___, Zip Code: _____ Marital Status: _____

Primary Phone: (____) _____ - _____ Alternate Phone: (____) _____ - _____ Last 4 of SSN: _____

E-Mail: _____ Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone: (____) _____ - _____

Pharmacy with Location: _____ Phone: (____) _____ - _____

Eye and Vision History: Date of Last Eye Exam: _____

Glaucoma	Cataracts	Keratoconus	Amblyopia	Macular Degeneration	Dry Eye	Floaters
Flashes	Injury	Ulcers	Uveitis	Retinal Detachment	Eye Surgery	Lasik
Strabismus	Other: _____					

Health History: Date of Last Physical: _____ Are you a current or former smoker?: Y/N Years Used: _____

Gastrointestinal: Y/N Nerviosos: Y/N Endocrine: Y/N Cardiovascular: Y/N Mental: Y/N Genitourinary: Y/N

Respiratory: Y/N Dermatology: Y/N Immunology: Y/N Musculoskeletal: Y/N Blood/Lymph: Y/N Ear/Nose/Throat: Y/N

Other: please specify: _____

Diabetic: Y/N Date of Diagnosis: _____ Type I / Type II Last HgA1c: _____

Medications: _____

Allergies: _____

Surgical History: _____

Do you wear glasses: Y/N Do you wear contacts: Y/N Brand/Type: _____

Family History:

Hypertension: Y/N Diabetes: Y/N Glaucoma: Y/N Macular Degeneration: Y/N Retinal Detachment: Y/N

Other, specify: _____

Emergency Contact Information: _____ Phone: (____) _____ - _____

Please Name who you would like information released to: _____

Patient Signature: _____ Date: _____