Honolulu Eye Clinic Patient Registration Form

Patient Information - Please Print Clearly

Last: _____ **First:** _____ **Middle:**_____

Title: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. **Suffix/Degree:** _____

Nickname (or preferred name): _____

Address: _____ **Apartment #:** _____

City, State, Zip: _____ **Date of Birth**: _____/_____/_____

Gender: ☐ F M **Marital status:** _____

Primary Phone Number: _____ **check one:** ☐ Home ☐ Cell Work

Secondary Phone Number: _____ **check one:** ☐ Home ☐ Cell ☐ Work

Email: _____

Is it okay to send you text messages and/or appointment reminders? ☐ Yes ☐ NO, do not text me

Is it okay to send you email messages and/or appointment reminders? ☐ Yes ☐ NO, do not email me

Employment of Patient (or guardian)

Employer:_____

Occupation:_____

Work phone:_____

Primary Care Physician

Full Name:_____

Phone:_____

Address:_____

Spouse (or emergency contact) Information

Name_____

Employer:_____

Occupation:_____Phone:_____

Whom may we thank for sending you to our clinic?

Referred by Dr._____

Referred by: ☐ Patient_____

☐ Friend_____

☐ Internet_____

Other:_____

Health Insurance information

	Insurance Company	Subscriber Name	Relation	Subscriber #	Subscriber Birthdate
Primary	_____	_____	_____	_____	____/____/____
Secondary	_____	_____	_____	_____	____/____/____
Other	_____	_____	_____	_____	____/____/____

Honolulu Eye Clinic Medical History Questionnaire

Do you have now or have you recently had: (please check YES or NO)

Fever, chills, night sweats, unexplained fatigue? ☐Y ☐N _____
Weight gain or loss over 10 lbs in the last year? ☐Y ☐N _____

Loss of vision ☐Y ☐N _____
Blurred vision ☐Y ☐N _____
Loss of side vision ☐Y ☐N _____
Double vision ☐Y ☐N _____
Dry eyes ☐Y ☐N _____
Eye discharge ☐Y ☐N _____
Red eyes ☐Y ☐N _____
Sandy or gritty eyes ☐Y ☐N _____
Itchy eyes ☐Y ☐N _____
Burning eyes ☐Y ☐N _____
Eye foreign body sensation ☐Y ☐N _____
Eye pain or soreness ☐Y ☐N _____
Chronic infection of eyes ☐Y ☐N _____
Chronic infection of lids ☐Y ☐N _____
Tearing or watering eyes ☐Y ☐N _____
Crossed eyes ☐Y ☐N _____
Lazy eye ☐Y ☐N _____
Droopy eyelid(s) ☐Y ☐N _____

Ear, nose, throat problems, loss of hearing, smell? ☐Y ☐N _____
Sinusitis, vertigo, dry mouth, difficulty swallowing? ☐Y ☐N _____

Heart / circulation problems? ☐Y ☐N _____
Heart attack or angina? ☐Y ☐N _____
Congestive heart failure? ☐Y ☐N _____
Irregular heart beat? ☐Y ☐N _____
Cardiac pacemaker or valve? ☐Y ☐N _____
High blood pressure? ☐Y ☐N _____

Respiratory problems? ☐Y ☐N _____
Asthma; chronic cough? ☐Y ☐N _____
Emphysema; bronchitis? ☐Y ☐N _____
Tuberculosis or +PPD? ☐Y ☐N _____

Gastrointestinal problems? ☐Y ☐N _____
Ulcers, diverticulitis, colitis? ☐Y ☐N _____
Frequent diarrhea? ☐Y ☐N _____
Liver disease, hepatitis? ☐Y ☐N _____

Genitourinary disease? ☐Y ☐N _____
Kidney, bladder problems? ☐Y ☐N _____
Prostate, stones, infections? ☐Y ☐N _____
Urinary frequency, STD? ☐Y ☐N _____

Muscle weakness, fatigue? ☐Y ☐N _____
Arthritis, joint swelling? ☐Y ☐N _____
Low back pain, gout? ☐Y ☐N _____
Rheumatoid / osteoarthritis? ☐Y ☐N _____

Skin, hair, or nail problems? ☐Y ☐N _____
Eczema, psoriasis, rosacea? ☐Y ☐N _____
Skin cancer, infections? ☐Y ☐N _____

Neurologic disease? ☐Y ☐N _____
Stroke, seizures, tremor? ☐Y ☐N _____
Parkinson's disease? ☐Y ☐N _____
Memory loss, disorientation? ☐Y ☐N _____
Anxiety, depression? ☐Y ☐N _____

Diabetes, date of onset? ☐Y ☐N _____
Thyroid disease? ☐Y ☐N _____
Adrenal or pituitary disease? ☐Y ☐N _____

Blood disorders, anemia? ☐Y ☐N _____
Easy bruising; clotting? ☐Y ☐N _____
AIDS or HIV positive? ☐Y ☐N _____
Cancer or tumor, type, date? ☐Y ☐N _____

Are you pregnant? ☐Y ☐N _____
Expected delivery date? _____

Family History: Among your **blood relatives**, have they had:
Blindness ☐Y ☐N _____
Cataracts ☐Y ☐N _____
Glaucoma ☐Y ☐N _____
Macular degeneration ☐Y ☐N _____
Retinal detachment or disease ☐Y ☐N _____
Lazy eye or muscle imbalance ☐Y ☐N _____
Cancer or tumor ☐Y ☐N _____
Diabetes mellitus ☐Y ☐N _____
Heart disease ☐Y ☐N _____
High blood pressure ☐Y ☐N _____
Bleeding disorder ☐Y ☐N _____
Other _____

Are you a smoker? ☐Y ☐N How many packs per day?_____
Do you drink alcohol? ☐Y ☐N How many drinks per day?_____
Do you use drugs? ☐Y ☐N

Have you had any **eye surgery, laser**, or injury? ☐Y ☐N
Names & dates of operation(s) or injuries:_____

Eye drops/medications: _____

Prescription & nonprescription medications:_____

Do you have any allergies to medication? ☐Y ☐N
If "Yes", please list:_____

Do you currently wear contact lenses? ☐Y ☐N
If yes, ☐Soft contacts ☐Rigid Gas Permeable (RGP)
Do you currently wear glasses? ☐Y ☐N

Details regarding above YES answers:_____