Honolulu Eye Clinic Patient Registration Form

Patient Information - Please Print Clearly		
Last: First:	Middle:	
Title: Mr. Ms. Dr. Suffix/Degree:		
Nickname (or preferred name):		
Address:	Apartment #:	
City, State, Zip:	Date of Birth: /	
Gender: F M Marital status:		
Primary Phone Number:		
Secondary Phone Number:		
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)	Primary Care Physician	
Employer:	Full Name:	
Occupation:	Phone:	
Work phone:	Address:	
Spouse (or emergency contact) Information	Whom may we thank for sending you to our clinic?	
Name	Referred by Dr	
	Referred by: Patient	
Employer:	Friend	
	Internet	
Occupation:Phone:	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 sweets, Neurologic disease? Neurologic diseases? Neurologic diseases Neurologic Neurolog		
Weight gain or loss over	Fever, chills, night sweats,	Neurologic disease?
Weight gain or loss over	unexplained fatigue?	Stroke, seizures, tremor?
Loss of vision		
Anxiety, depression? Y N		
Blurred vision Loss of side vision Dry eyes Eye discharge Red eyes Sandy or gritiv ges Inchy eyes Eye pain or soreness Chronic infection of leye Ch		
Blurred vision	Loss of vision Y N	Anxiety, depression? Y N
Loss of side vision		
Adrenal or pituitury disease? V N Blood disorders, anemia? V N Blood fire districts, and the plant of the pl		
Blood disorders, anemia?		
Easy braising; clotting? Y N N N N N N N N N		
Red eyes		
Red eyes		Easy bruising; clotting?
Sandy or gritty eyes 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 W N Catarac		
Lety eyes		
Burning eyes Eye foreign body sensation Eye pain or soreness Chronic infection of eyes Catracts Glaucoma Grossed eyes Lazy eye or muscle imbalance Lazy		
Eye pain or soreness		
Eye pain or soreness		Expected delivery date?
Chronic infection of eyes Chronic infection of lids Chronic infection of lids Chronic infection of lids Cataracts Cataracts Cataracts Glaucoma Macular degeneration Retinal detachment or disease Y N Retinal deta		*
Chronic infection of leyes Chronic infection of lids Fearing or watering eyes Crossed eyes Lazy eye Lazy ey Lazy eye Lazy eye Lazy eye Lazy eye Lazy eye Lazy eye Laz		
Cataracts Tearing or watering eyes Ty N Saturd detachment or disease Ty N Saturd disease, or injury Ty N Saturd disease, or injury Ty N Sames & dates of operation(s) or injuries: Eye drops/medications: Eye drops/medications: Eye drops/medications: Feye drops/medi	Chronic infection of eyes YN	
Tearing or watering eyes		= -
Crossed eyes		
Retinal detachment or disease Y N N Cancer or tumor Diabetes mellitus Y N N Diabetes mellitus Y N Diabetes mellitus Diabetes Diabetes mellitus Diabetes mellitus Diabetes mellitus Dia		Macular degeneration Y N
Lazy eye or muscle imbalance Y N N Cancer or tumor Y N N Diabetes mellitus Y N Diabetes mellitus Diabetes me		
Cancer or tumor Cancer or Cancer or Cancer Ca		
Diabetes mellitus		
Sinsusting vertigo, dry mouth, difficulty swallowing? Y N N	Ear, nose, throat problems,	
Sinustits, vertigo, dry mouth, difficulty swallowing? Y N High blood pressure Bleeding disorder Other N Heart / circulation problems? 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: Tuberculosis or +PPD? N Have you had any eye surgery, laser, or injury? Y N Names & dates of operations Eye drops/medications: Eye drops/medications: Eye drops/medications: Genitourinary disease? Y N N Prescription & nonprescription medications: Genitourinary disease? Y N Do you have any allergies to medication? Y N If "Yes", please list: Skin, hair, or nail problems? Y N If yes, Soft contacts Rigid Gas Permeable (RGP) Skin cancer, infections? Y N If yes, Soft contacts Rigid Gas Permeable (RGP) Skin cancer, infections? Y N Do you currently wear glasses? Y N If yes, Soft contacts Rigid Gas Permeable (RGP) Skin cancer, infections? Y N Do you currently wear glasses? Y N If yes, Soft contacts Rigid Gas Permeable (RGP) Skin cancer, infections? Y N Do you currently wear glasses? Y N If yes, Soft contacts Rigid Gas Permeable (RGP) Skin cancer, infections? Y N Skin cancer,		
difficulty swallowing?	Sinusitis, vertigo, dry mouth	
Heart / circulation problems? 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 drink alcohol? Y N How many drinks per day? Do you drink alcohol? Y N How many drinks per day? Do you drink alcohol? Y N How many drinks per day? Do you use drugs? Y N N Have you had any eye surgery, laser, or injury? Y N N N N N N N N N		
Heart / circulation problems?		Bleeding disorder
Heart attack or angina? Y N N Do you drink alcohol? Y N How many packs per day? Do you drink alcohol? Y N How many packs per day? Do you drink alcohol? Y N How many drinks per day? Do you drink alcohol? Y N How many drinks per day? Do you use drugs? Y N N Have you had any eye surgery, laser, or injury? Y N N N N N N N N N		
Congestive heart failure?		
Irregular heart beat? Cardiac pacemaker or valve? High blood pressure? Asthma; chronic cough? Emphysema; bronchitis? Tuberculosis or +PPD? Ulcers, diverticulitis, colitis? Frequent diarrhea? Liver disease, hepatitis? Genitourinary disease? Kidney, bladder problems? Urinary frequency, STD? Muscle weakness, fatigue? Arthritis, joint swelling? Low back pain, gout? Rheumatoid / osteoarthritis? Kin, hair, or nail problems? Kin agnoration of the state of operation of the state of operation of the state of operation of injuries: Eye drops/medications: Eye drops/medications: Eye drops/medications: Eye drops/medications: Fequent diarrhea? Frequent diarrhea? Frequent diarrhea? In the state of operation of injury? Frequent diarrhea? Frequent diarrhea? Frequent diarrhea? In the state of operation of injury? Fey of operation of injury? Names & dates of operation of injury? Fey of operation of injury. Fey of ope		
Cardiac pacemaker or valve? Y N Have you had any eye surgery, laser, or injury? Y N Names & dates of operation(s) or injuries: Respiratory problems?		
High blood pressure?		
Respiratory problems? Asthma; chronic cough? Emphysema; bronchitis? Tuberculosis or +PPD? Y N Gastrointestinal problems? Ulcers, diverticulitis, colitis? Frequent diarrhea? Liver disease, hepatitis? Genitourinary disease? Kidney, bladder problems? Y N V N Urinary frequency, STD? Muscle weakness, fatigue? Arthritis, joint swelling? Low back pain, gout? Rheumatoid / osteoarthritis? Skin, hair, or nail problems? Y N Skin, hair, or nail problems? Y N Skin cancer, infections? Y N Do you currently wear contact lenses? Y N If 'yes, Soft contacts Rigid Gas Permeable (RGP) Do you currently wear glasses? Y N		
Asthma; chronic cough?		* ''
Asthma; chronic cough?		injuries:
Tuberculosis or +PPD?		
Gastrointestinal problems?		Eva dvana/madiaations:
Gastrointestinal problems?		Eye drops/medications:
Ulcers, diverticulitis, colitis?		
Frequent diarrhea?		
Liver disease, hepatitis?	Frequent diarrhea?	
Genitourinary disease?		Drogoriution & nonprescription modications:
Kidney, bladder problems?		riescription & nonprescription medications:
Prostate, stones, infections?		
Urinary frequency, STD?		
Urinary frequency, STD?	Prostate, stones, infections? \(\subseteq Y \subseteq N \)	
Muscle weakness, fatigue?		Do you have any allergies to medication? DV DV
Arthritis, joint swelling? Low back pain, gout? Rheumatoid / osteoarthritis? Y N Rheumatoid / osteoarthritis? Y N Skin, hair, or nail problems? Eczema, psoriasis, rosacea? Y N Eczema, psoriasis, rosacea? Skin cancer, infections? Y N Do you currently wear contact lenses? If yes, Soft contacts Rigid Gas Permeable (RGP) Do you currently wear glasses? Y N		
Low back pain, gout?	Intuscie weakness, latigue?	II 'Yes', please list:
Rheumatoid / osteoarthritis?		
Skin, hair, or nail problems? Y N Do you currently wear contact lenses? Y N If yes, Soft contacts Rigid Gas Permeable (RGP) Skin cancer, infections? Y N Do you currently wear glasses? Y N Do you currently wear glasses?	Low back pain, gout?	
Eczema, psoriasis, rosacea?	Rheumatoid / osteoarthritis?	
Eczema, psoriasis, rosacea?	Skin hair or nail problems? TV N	Do you currently wear contact lenses? IV N
Skin cancer, infections?		
Details regarding above YES answers:	Skill cancer, injections?	Do you currently wear glasses?
Details regarding above YES answers:		
	Details regarding above YES answers:	
		