

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
Secondary Phone Number: _____		check one:		Home	Cell
Work		Work			
Email: _____					
Is it okay to send you text messages and/or appointment reminders? <input type="checkbox"/> Yes <input type="checkbox"/> NO, do not text me					
Is it okay to send you email messages and/or appointment reminders? <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____
Employer: _____	Referred by: <input type="checkbox"/> Patient _____
Occupation: _____ Phone: _____	<input type="checkbox"/> Friend _____
	<input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Weight gain or loss over 10 lbs in the last year? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Neurologic disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Stroke, seizures, tremor? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Parkinson's disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Memory loss, disorientation? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Anxiety, depression? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Loss of vision <input type="checkbox"/> Y <input type="checkbox"/> N _____ Blurred vision <input type="checkbox"/> Y <input type="checkbox"/> N _____ Loss of side vision <input type="checkbox"/> Y <input type="checkbox"/> N _____ Double vision <input type="checkbox"/> Y <input type="checkbox"/> N _____ Dry eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Eye discharge <input type="checkbox"/> Y <input type="checkbox"/> N _____ Red eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Sandy or gritty eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Itchy eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Burning eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Eye foreign body sensation <input type="checkbox"/> Y <input type="checkbox"/> N _____ Eye pain or soreness <input type="checkbox"/> Y <input type="checkbox"/> N _____ Chronic infection of eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Chronic infection of lids <input type="checkbox"/> Y <input type="checkbox"/> N _____ Tearing or watering eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Crossed eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____ Lazy eye <input type="checkbox"/> Y <input type="checkbox"/> N _____ Droopy eyelid(s) <input type="checkbox"/> Y <input type="checkbox"/> N _____	Diabetes, date of onset? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Thyroid disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Adrenal or pituitary disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Blood disorders, anemia? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Easy bruising; clotting? <input type="checkbox"/> Y <input type="checkbox"/> N _____ AIDS or HIV positive? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Cancer or tumor, type, date? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Ear, nose, throat problems, loss of hearing, smell? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Sinusitis, vertigo, dry mouth, difficulty swallowing? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Expected delivery date? _____ Family History: Among your blood relatives , have they had: Blindness <input type="checkbox"/> Y <input type="checkbox"/> N _____ Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N _____ Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N _____ Macular degeneration <input type="checkbox"/> Y <input type="checkbox"/> N _____ Retinal detachment or disease <input type="checkbox"/> Y <input type="checkbox"/> N _____ Lazy eye or muscle imbalance <input type="checkbox"/> Y <input type="checkbox"/> N _____ Cancer or tumor <input type="checkbox"/> Y <input type="checkbox"/> N _____ Diabetes mellitus <input type="checkbox"/> Y <input type="checkbox"/> N _____ Heart disease <input type="checkbox"/> Y <input type="checkbox"/> N _____ High blood pressure <input type="checkbox"/> Y <input type="checkbox"/> N _____ Bleeding disorder <input type="checkbox"/> Y <input type="checkbox"/> N _____ Other _____
Heart / circulation problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Heart attack or angina? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Congestive heart failure? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Irregular heart beat? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Cardiac pacemaker or valve? <input type="checkbox"/> Y <input type="checkbox"/> N _____ High blood pressure? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Are you a smoker? <input type="checkbox"/> Y <input type="checkbox"/> N How many packs per day? _____ Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N How many drinks per day? _____ Do you use drugs? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Respiratory problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Asthma; chronic cough? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Emphysema; bronchitis? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Tuberculosis or +PPD? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Have you had any eye surgery, laser , or injury? <input type="checkbox"/> Y <input type="checkbox"/> N Names & dates of operation(s) or injuries: _____
Gastrointestinal problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Ulcers, diverticulitis, colitis? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Frequent diarrhea? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Liver disease, hepatitis? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Eye drops/medications: _____ _____ _____ Prescription & nonprescription medications: _____ _____ _____
Genitourinary disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Kidney, bladder problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Prostate, stones, infections? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Urinary frequency, STD? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you have any allergies to medication? <input type="checkbox"/> Y <input type="checkbox"/> N If "Yes", please list: _____ _____
Muscle weakness, fatigue? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Arthritis, joint swelling? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Low back pain, gout? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Rheumatoid / osteoarthritis? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you currently wear contact lenses? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, <input type="checkbox"/> Soft contacts <input type="checkbox"/> Rigid Gas Permeable (RGP) Do you currently wear glasses? <input type="checkbox"/> Y <input type="checkbox"/> N
Skin, hair, or nail problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Eczema, psoriasis, rosacea? <input type="checkbox"/> Y <input type="checkbox"/> N _____ Skin cancer, infections? <input type="checkbox"/> Y <input type="checkbox"/> N _____	

Details regarding above YES answers: _____

