Honolulu Eye Clinic Patient Registration Form

Patient Information - Please Print Clearly

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

Nickname (or preferred name): _____ **School & Grade:** _____

Address: _____ **Apartment #:** _____

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

Gender: ☐ F ☐ M **Email:** _____

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

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

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

Family Physician or Pediatrician:

Name:_____

Address:_____

Phone:_____ Fax:_____

Whom may we thank for sending you to our clinic?

Referred by another Doctor_____

Referred by:

Patient_____

Friend_____

Internet

Other:_____

Parent/Guardian #1:

Name:_____ Day Phone:_____

Employer:_____Cell Phone:_____

Occupation:_____

Email:_____

Parent/Guardian #2:

Name:_____ Day Phone:_____

Employer:_____Cell Phone:_____

Occupation:_____

Email:_____

Health Insurance information

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

Pediatric Ophthalmology/Adult Strabismus - New Patient Questionnaire

History of Eye Problems:

Yes	No	Glasses/Contact lenses/Prisms	
☐	☐	Glasses	How old is current pair?
☐	☐	Contact lenses	How old is current pair?
☐	☐	Hard, Gas permeable, or Soft?	Contact lens cleaning solutions:
☐	☐	Prisms	How long?

Yes	No	Other eye symptoms	Age or How Long?	Yes	No	Other eye symptoms	Age or How Long?
☐	☐	Eye exam by specialist		☐	☐	Eye injury	
☐	☐	Patching		☐	☐	Stye	
☐	☐	Eye exercises		☐	☐	Recurring “pink eye”	
☐	☐	Eye muscle surgery		☐	☐	Cataract	
☐	☐	Other eye surgery		☐	☐	Glaucoma	
☐	☐	Diabetic eye disease		☐	☐	Other:	

Recent Eye Symptoms:

Yes	No		How long?	Yes	No		How long?
☐	☐	Crossed or wandering eye		☐	☐	Drooping eye lid	
☐	☐	Excessive squinting		☐	☐	Tired eyes when reading	
☐	☐	Double vision		☐	☐	Dry or gritty sensation	
☐	☐	Excessive eye rubbing		☐	☐	Itching eyes	
☐	☐	Frequent tearing or discharge		☐	☐	Red eyes	
☐	☐	Blurred vision		☐	☐	Flashing lights or floaters	
☐	☐	Light sensitivity		☐	☐	Poor peripheral vision	

Other eye symptoms not mentioned above:

Other Recent Symptoms:

Yes	No	Symptom	How long?	Yes	No	Symptom	How long?
☐	☐	Weight loss		☐	☐	Diarrhea/constipation	
☐	☐	Excessive fatigue		☐	☐	Frequent/painful urination	
☐	☐	Fever		☐	☐	Blood in urine	
☐	☐	Earaches		☐	☐	Muscle weakness	
☐	☐	Sore throat		☐	☐	Rash	
☐	☐	Dry mouth		☐	☐	Headaches	
☐	☐	Chest pain		☐	☐	Dizziness	
☐	☐	Rapid heart rate		☐	☐	Numbness	
☐	☐	Shortness of breath		☐	☐	Paralysis	
☐	☐	Swelling of hands/feet		☐	☐	Memory loss	
☐	☐	Loss of appetite		☐	☐	Change in school performance	
☐	☐	Vomiting		☐	☐	Clumsiness	

Family History: Which of the patient's ***relatives*** have had any of the following?

Yes	No	**Eye Conditions in other family members:**	Which relative?				
☐	☐	Glasses ***before age 6***	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Amblyopia (“lazy eye”)	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Patching treatment	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Strabismus (“crossed” or “wandering” eye)	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Eye muscle surgery	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Cataracts ***in childhood***	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Glaucoma ***in childhood***	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Blindness ***in childhood***	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Eye disease caused by diabetes	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Macular degeneration	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Retinal detachment	☐Father	☐Mother	☐Sister	☐Brother	Other:
☐	☐	Other serious eye disease ***in childhood***	☐Father	☐Mother	☐Sister	☐Brother	Other:

Yes	No	**Medical conditions in other family members:**	Yes	No	
☐	☐	Complications from anesthesia	☐	☐	High blood pressure
☐	☐	Genetic disease (runs in family)	☐	☐	Stroke
☐	☐	Heart disease	☐	☐	Cancer
☐	☐	Diabetes	☐	☐	Other serious illnesses in family members:

Medical History

Yes	No	Condition	Yes	No	Condition	Yes	No	
☐	☐	Frequent ear infections	☐	☐	Diabetes	☐	☐	Neurologic disease
☐	☐	Sinus disease	☐	☐	Anemia	☐	☐	Seizures or stroke
☐	☐	Heart disease	☐	☐	Kidney disease	☐	☐	Depression
☐	☐	High blood pressure	☐	☐	Thyroid problem	☐	☐	Cancer
☐	☐	Asthma	☐	☐	Arthritis	☐	☐	Missing immunizations

Major illnesses or previous surgery not mentioned above (other than eye problems):

Medications

List any **eye drops** the patient is taking:

Eye drop and frequency	☐ NONE

List any **medications** the patient is taking:

Medication and dosage	☐ NONE

Birth history (*Pediatric patients only*): Birth weight: ____ lb, ____ oz

Yes	No	Condition	Please provide details
☐	☐	Problems during pregnancy	Describe:
☐	☐	Problems during delivery	Describe:
☐	☐	Forceps delivery	
☐	☐	Cesarean section	
☐	☐	Delivered early	How many weeks?
☐	☐	Baby kept in hospital due to illness	Why and how long?