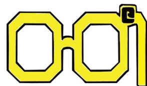

Vision Care Center of Hawaii

94-050 Farrington Hwy, B1-1 Waipahu, HI 96797 (808) 677-1544

New Patient Information

Patient's Full Name ☐ **Miss** ☐ **Mrs.** ☐ **Mr.** ____

DOB ____ / ____ / _____ **Gender** ☐ **Male** ☐ **Female**
Email_______________________________
Occupation___________________________
Employer ____________________________
Grade/School __________________________
Hobbies/Sports _________________________
Primary Care Physician____________________
Other Medical Specialists___________________
Referred by_____________________________

Last 4 of SSN___________
Address ____________________________
City/State ____________________ **Zip** _______
Home Phone __________________________
Cell Phone ____________________________
Work Phone ___________________________
Date Last Seen by PCP ___________________
How did you hear about us?___________________

Race ☐ **American/Alaskan Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Hispanic**
☐ **Native/Part Hawaiian or Pacific Islander** ☐ **White**

Vision Insurance ______________________ Member ID _________________ Group # _______________
Policy Holder's Name ______________________ DOB ____/____/____ Last 4 of SSN____________________

Medical Insurance ______________________ Member ID _________________ Group #_______________
Policy Holder's Name ______________________ DOB ____/____/____ Last 4 of SSN ___________________

Patient History

Last Eye Exam: ______________ **Reason for today's visit**:__________________________________

Do you currently experience any of the following? (Please check all that apply)
☐ Blurred vision at distance ☐ Blurred vision at near ☐ Double vision ☐ Itchy eyes ☐ Dry Eyes ☐ Eye strain
☐ Eye Pain ☐ Floaters ☐ Flashes ☐ Red eyes ☐ Other ___________

Do you currently wear contact lenses? ☐ Yes ☐ No
If yes, what brand/type do you wear? ____

Do you want to have a contact lens exam today? ☐ Yes ☐ No

History of Eye Conditions:	**You**	**Family Member(s): Please list family member(s)**
Blindness	☐	☐
Glaucoma	☐	☐
Cataract	☐	☐
Eye Turn	☐	☐
Lazy Eye	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Retinal Disease	☐	☐
Eye Injury	☐	☐

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergy/Immunologic

__Lupus (SLE)

__Rheumatoid Arthritis

__Environmental Allergies

__Seasonal Allergies

Ear, Nose, & Throat

__Sinusitis

__Upper Respiratory Infections

__Hearing Loss

Gastrointestinal

__Crohn's Disease

__Colitis

__Acid Reflux/Ulcer

Integumentary

__Eczema

__Rosacea

__Psoriasis

Psychiatric

__Depression

__Bi-polar

__Schizophrenia

Cardiovascular

__High Blood Pressure

__Heart Disease

__Vascular Disease

__High Cholesterol

Endocrine

__Diabetes

__Year Diagnosed

A1c___ BS___

__Thyroid Dysfunction

Respiratory

__Asthma

__Emphysema

__Bronchitis

__Tuberculosis

Muscle/Skeletal

__Arthritis

__Ankylosing Spondylitis

__Fibromyalgia

Genitourinary

__Urinary Infection

__Herpes

__HIV positive

__Chlamydia

Hematologic/Lymphatic

__Anemia

__Leukemia

__Bleeding Disorder

Neurological

__Multiple Sclerosis

__Epilepsy

__Tremors

__Headaches

General Health

__Weight loss/gain

__Fever

__Fatigue

__Trauma

Please list any other conditions not listed ____

Please list all your current **medications** (include eye drops, over the counter, and vitamins)___________

____

____

Please list any **allergic reactions** to medication or eye drops________________________________

____

Please list all major **surgeries** (include eye surgery): ______________________________________

____

Women: Are you currently pregnant and/or nursing? (if applicable) ☐ Yes ☐ No

Social/Tobacco/Alcohol History (Please check all that apply)

☐ Current smoker, __ per day ☐ Former Smoker ☐ Never a smoker

☐ Alcohol use, __ per day ☐ Recreational Drug use, __ per day

Are you vaccinated for COVID-19? ☐ Yes ☐ No

*I request that payment of authorized Insurance benefits for any services furnished to me, be made on my behalf to **Vision Care Center of Hawaii LLC.** I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not paid by my insurance plan and I understand the Notice of Privacy Practices.*

Signature of Patient/Parent/Legal Guardian ______________________________ Date ____________

Doctor Reviewed ______