Patient Name: _____ **DOB**____/____/_____ **Gender:** □ M □ F **Race:** □ American/Alaskan Indian

□ Asian □ Black or African American □ Hispanic □ Native/Part Hawaiian or Pacific Islander □ White **Preferred Language**: □ English □ Spanish

Ethnicity: □ Hispanic/ Latino □ Native Hawaiian/Pacific Islander □ Not Hispanic or Latino **Contact Me By**: □ Email □ Postal □ Telephone

Primary Care Physician: _____ Date Last Seen: _____ Last Eye Examination: _____
Last Eye Doctor: _____

Other Medical Specialists: _____

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____
_____

List all major surgeries (Eye Surgery included):_____
_____

List any **allergic reactions** to **medications or eye drops**:
_____
_____

Please indicate if any of the symptoms/conditions apply to you or a family member (blood relatives only).

Symptoms:	History of Conditions:	You	Family Member(s)
□ Change in Far VA	Blindness	□	□
□ Change Near VA	Glaucoma	□	□
□ Double Vision	Cataract	□	□
□ Floaters/Spots	Eye Turn	□	□
□ Flashes	Lazy Eye	□	□
□ Red Eyes	Macular Degeneration	□	□
□ Itchy Eyes	Retinal Detachment	□	□
□ Dry Eyes	Retinal Disease	□	□
□ Eye Pain/Ache	Eye Injury	□	
□ Headaches			

Women: Are you Pregnant ? Yes__ □ No__ □Are you breast feeding? Yes __ No ___□

Computer/Video Devices: _____ hours per day
Hobbies/Sports Activities: _____

******Office Use Only******

Appointment: _____
Check-in: _____
Data Entry: _____
Dr Exam In: _____ Out: _____

	Unaided VA		Aided VA	
Far	OD	OS	OD	OS
	20/	20/	20/	20/
PH	20/	20/	20/	20/
Near	OD	OS	OD	OS
	20/	20/	20/	20/

Color Vision: ___/9 FDT: □ Nl □ Abnl

Stereo: __Monkey (100) __6 (80) __7 (60) __ 9 (40) sec of arc

BP/Pulse: _____/_____ _____

Reason for today's visit:_____

Review of Systems

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

Allergic/Immunologic
__ None
__ Lupus (SLE)
__ Rheumatoid Arthritis
__ Environmental Allergies
__ Seasonal Allergies
__ Other (e.g. Latex)

Ear, Nose and Throat
__ None
__ Sinusitis
__ Upper Respiratory Infections
__ Other

Gastrointestinal
__ None
__ Crohn's Disease
__ Colitis
__ Acid Reflux/Ulcer
__ Other

Skin /Integumentary
__ None
__ Eczema
__ Rosacea
__ Psoriasis
__ Other

Psychiatric
__ None
__ Depression
__ Bi-Polar
__ Schizophrenia
__ Other

Cardiovascular
__ None
__ High Blood Pressure
__ Heart Disease
__ Stroke
__ Vascular Disease
__ High Blood Cholesterol

Endocrine/Glands
__ None __ Diabetes
__ Insulin __ Pills
___ Years Diabetic
A1-C ___ B/S _____
__ Hormone Dysfunction
__ Thyroid Dysfunction

Respiratory
__ None
__ Asthma
__ Bronchitis
__ Emphysema
__ Other

Muscle/Skeletal
__ None
__ Arthritis
__ Fibromyalgia
__ Ankylosing Spondylitis
__ Other

Genital/Urinary
__ None
__ Urinary Infection
__ HIV Positive
__ Herpes/Chlamydia
__ Other

Hematologic/Lymphatic
__ None
__ Anemia
__ Leukemia
__ Bleeding Disorder
__ Other

Neurological
__ None
__ Multiple Sclerosis
__ Epilepsy
__ Tremors
__ Other

Weight_____ Height_____

General Health
__ No known problems
__ Weight loss/gain
__ Fever
__ Fatigue
__ Trauma

Social Tobacco/Alcohol History
Tobacco Use: __ Non-Smoker ___Former Smkr
__ Current Smoker ____pkg per day
__ **Illicit Substance/Drugs**_____
Use: _____ per day _____ per wk
Alcohol Use: _____ per day _____ per wk

Other medical conditions or concerns you want Doctor to know about: _____

Doctor Reviewed _____

PATIENT INFORMATION

NAME:_____ BIRTHDATE:_____

ADDRESS:_____ CITY_____, HI, ZIP _____

HOME PHONE:_____ WORK/DAY PHONE:_____ CELL PHONE:_____

OCCUPATION/EMPLOYER_____ OK ☐ send text messages

GRADE/ SCHOOL_____/_____

EMAIL:_____

Medical Insurance_____ **Vision Insurance**_____

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to **Roger Christian Ede, O.D., Inc.** I authorize any holder of medical information about me to release 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 (HIPAA-Revsed September 2013):

X_____ **Date**_____
Signature of Patient/ Parent/ Legal Guardian