



Welcome to Ohana Eye Care!

Patient Information

Name:	Date of Birth:
Address:	
Ethnicity:	Gender:
Occupation:	Employer:
Primary Phone #	cell work home
Secondary Phone #	cell work home
Email address:	
Preferred Method of Contact: email text phone	
Referred by:	

Insurance Information

Primary Insurance Company:	
Insurance ID #	
Subscriber Name:	Date of Birth:
Relationship to Subscriber: Self Spouse Dependent Child Other	
Secondary Insurance Company:	
Insurance ID #	

*****Please present any insurance cards and forms to the optical staff.*****

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by that doctor. I also understand that I am responsible for any charges not covered by my insurance.

Patient Name (Please Print):	Date:
Patient Signature:	

Patient History Form

Today's Date _____

Patient Name _____ Patient Date of Birth _____

Medical History

Are you allergic to any medications? No Yes (describe) _____

Please list any current medications (with dosage) you are taking (including over-the-counter eye drops, vitamins or supplements, aspirin and oral contraceptives).

List any major injuries, surgeries and/or hospitalizations you have had and date(s). _____

Have you had any of the following:

- Crossed eyes Lazy eye Drooping eyelid Eye infection
 Eye injury Eye Surgery Glaucoma Cataracts Macular degeneration

Do you or have you ever experienced any problems in the following areas?

System Constitutional	No	Yes	Endocrine	No	Yes	Gastrointestinal	No	Yes
Fever/Weight loss/Gain	N	Y	Non-insulin Dependent Diabetes	N	Y	Crohn's	N	Y
			Insulin Dependent Diabetes	N	Y	Colitis	N	Y
			Thyroid Dysfunction	N	Y	Ulcer	N	Y
			Hormonal Dysfunction	N	Y	Digestive	N	Y
Integumentary			Respiratory			Genitourinary		
Eczema	N	Y	Asthma	N	Y	Genitals/Kidney/Bladder	N	Y
Psoriasis	N	Y	Chronic Bronchitis	N	Y			
Cancer	N	Y	Emphysema	N	Y	Allergy/Immunological		
			Cancer	N	Y	Drug Allergy	N	Y
Neurological			Vascular/Cardiovascular			Environmental Allergy	N	Y
Headaches	N	Y	High Blood Pressure	N	Y	Rheumatoid Arthritis	N	Y
Migraines	N	Y	High Cholesterol	N	Y	Lupus	N	Y
Seizures	N	Y	Stroke	N	Y	Psychiatric		
Multiple Sclerosis	N	Y	Heart Disease	N	Y	Depression	N	Y
Cancer	N	Y	Lymphatic/Hematological			Panic Disorder	N	Y
			Bleeding Problems	N	Y	Schizophrenia	N	Y
Ear/Nose/Throat						Pregnant/Nursing	N	Y
Allergies/Hay Fever	N	Y						
Sinus Congestion	N	Y						
Chronic Cough	N	Y						
Dry Throat/Mouth	N	Y						

Your Eye Symptoms – Do you (patient) experience any of the following?

Blurred Vision	N	Y	Flashing Lights	N	Y	Seeing Rings Around Lights	N	Y
Distorted Vision	N	Y	Painful Eyes	N	Y	Color Vision Difficulties	N	Y
Double Vision	N	Y	Gritty/Sandy Eyes	N	Y	Depth Perception Problem	N	Y
Red Eyes	N	Y	Aching Eyes	N	Y	Losing Place While Reading	N	Y
Watery Eyes	N	Y	Drawing/Pulling	N	Y	Night Vision Problems	N	Y
Itchy Eyes	N	Y	Dizziness	N	Y	Extreme Light Sensitivity	N	Y
Burning Eyes	N	Y	Excessive Squinting	N	Y	Discharge From Eyes	N	Y
Dry Eyes	N	Y	Other _____			Floating Spots	N	Y

Family History – Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y	Glaucoma	N	Y	Heart Disease	N	Y
Cornea Disease	N	Y	Lazy Eye	N	Y	Diabetes	N	Y
Crossed Eyes	N	Y	Macular Degeneration	N	Y	High Blood Pressure	N	Y
Retina Disease	N	Y	Cancer	N	Y	Other _____		

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.*

Yes, I would prefer to discuss my Social History Information directly with the doctor.

Occupation: _____

Do you drive? N Y If yes, do you have visual difficulty while driving? _____

If yes, please describe: _____

Do you use tobacco? N Y If yes, type/amount/how long? _____

Do you drink alcohol? N Y If yes, type/amount/how long? _____

Hobbies/Recreation/Sport – Please mark the boxes that apply to you.

Boating/fishing Gardening Photography Sewing Card playing Golf Racquetball/Handball Flying Swimming/Scuba Crafts Hunting Skiing Music

Do you wear: glasses contact lenses

Type of contact lenses: Rigid Soft Extended Wear Other

How often do you replace your contact lenses? Daily 1-2 Weeks

What brand of contact lenses do you wear? _____

Are they comfortable? No Yes

Monthly Quarterly Yearly Other _____

Please provide any additional information you would like to add:

The information provided is true and complete to the best of my knowledge.

Patient Signature (or Guardian if patient is a minor)	Date
Name of Person Completing Form (if not patient)	Relationship to Patient

For Office Use Only

Review date _____ Changes No Changes Provider signature _____

Review date _____ Changes No Changes Provider signature _____

Provider: Keep original signed form in patient's file