YAMAMOTO | INOUCHI DOCTORS OF OPTOMETRY

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

SALUTATION (PLEASE CIRCLE): MR. MRS. MISS MS. DR. OTHER:_____

DATE OF BIRTH | SOCIAL SECURITY NUMBER

HOME ADDRESS | HOME PHONE

CITY | STATE | ZIP CODE

MAILING ADDRESS

CITY | STATE | ZIP CODE

OCCUPATION | EMPLOYER | WORK PHONE

REFERRED BY

PERSON RESPONSIBLE FOR THE ACCOUNT: ☐ SELF ☐ SPOUSE ☐ PARENT

NAME

ADDRESS

INSURANCE INFORMATION: Please give all insurance cards to the receptionist.

Name of Medical or Vision Insurance Plans: _____

Medicare/Medicaid/Healthquest:_____

Other: _____

I understand that I am responsible for all charges for services provided by Daniel M. Yamamoto, O.D. & Tracie M. Inouchi, O.D. I authorize the release of any medical information to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment/participation with my insurance company.

X _____ – –

SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE

Daniel M. Yamamoto, O.D.
Tracie M. Inouchi. O.D.

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1441 Kapiolani Boulevard, Suite 1110
Honolulu, Hawai'i 96814

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MEDICAL HISTORY QUESTIONNAIRE (PAGE 1 OF 3)

NAME _____ DATE __ __ __ __ DATE OF LAST EYE EXAM

■ List any **MEDICATIONS** you currently take (Prescription and Over-the-Counter)

■ Do you have any **ALLERGIES** to any medications? If "YES" list the medications. YES NO

■ List all **MAJOR ILLNESSES** (Glaucoma, Diabetes, High Blood Pressure, Heart Attack, etc.) or **INJURIES** (Concussion, etc.)

■ List any **SURGERIES** you have had (Cataract, Tonsillectomy, Appendectomy, etc.)

■ Have you had any **EYE CONDITIONS**? (Cataracts, Retinal Disease, Pink Eye, Crossed Eye, etc.)

■ Do you currently wear **CONTACT LENSES**? If "YES," how long have you worn them? What type of contact lenses and brand of solution?

YES NO Year(s) Month(s) | Type of Lens: Brand of Solution:

■ Do you wear **EYEGLASSES**? How long have you had the current prescription?

YES NO Year(s) Month(s)

■ Do you **CURRENTLY** have any problems in the following areas? If "YES," please provide information.

EYES	YES	NO	EXPLANATION OF CONDITION
GLAUCOMA, CATARACTS, RETINAL DISEASE			
LOSS OF VISION			
BLURRED VISION			
FLUCTUATING VISION			
DISTORTED VISION			
LOSS OF SIDE VISION			
DRYNESS			
MUCOUS DISCHARGE			

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MEDICAL HISTORY QUESTIONNAIRE (PAGE 2 OF 3)

EYES (Continued)	YES	NO	EXPLANATION OF CONDITION
REDNESS			
SANDY OR GRITTY FEELING			
ITCHING			
DROOPING EYELIDS			
FOREIGN BODY SENSATION EXCESS TEARING / WATERING			
GLARE / LIGHT SENSITIVITY			
EYE PAIN OR SORENESS			
INFECTION OF EYE OR LID (STYE)			
TIRED EYES			
CROSSED EYES, LAZY EYE			
BURNING			

GENERAL, CONSTITUTIONAL	YES	NO	EXPLANATION OF CONDITION
FEVER			
WEIGHT LOSS			
OTHER			
CARDIOVASCULAR DISEASE (Heart, Vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, etc.)			
GASTROINTESTINAL (Ulcers, Intestinal disease)			
GENITAL, KIDNEY, BLADDER			
MUSCLE, BONES, JOINTS (Arthritis, etc.)			
SKIN (Skin Cancer, Warts, Acne, etc.)			
NEUROLOGICAL (Multiple Sclerosis, Headaches etc.)			
PSYCHIATRIC (Anxiety, Depression, Insomnia)			
ENDOCRINE (Diabetes, Hypothyroid, etc.)			
BLOOD, LYMPH (cholesterol, Anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay Fever, Lupus, Sjogrens)			
EARS, NOSE, THROAT (Sinus, Infection, Dry Mouth)			

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MEDICAL HISTORY QUESTIONNAIRE (PAGE 3 OF 3)

PLEASE INDICATE WHICH DISEASE APPLIES TO: M = Mother, F = Father, S = Sibling, G = Grandparent

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT
BLINDNESS			
GLAUCOMA			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE OR HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LUPUS			
STROKE			
THYROID DISEASE			
OTHER			

SOCIAL HISTORY	YES	NO	EXPLANATION OF CONDITION
DO YOU DRIVE? If "YES," do you have visual difficulty when driving?			

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