Patient Name: _____ **DOB**____/____/_____ **Gender:** ☐ M ☐ F **Preferred Language:** ☐ English ☐ Spanish

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

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**: ☐ No Known Allergies_____

Please indicate if any of the symptoms/conditions apply to you.

Your Symptoms:	History of Eye Conditions:	You:	Family Member:
☐ Change in Far Vision	☐ Blindness	☐	☐_____
☐ Change in Near Vision	☐ 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/Aches	☐ Eye Injury	☐	☐_____
☐ Headaches			

Reason for today's visit: _____

Women: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

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

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

Social Tobacco/Alcohol History
Tobacco Use: ☐ Non-Smoker ☐ Former Smoker
__ Current Smoker:____pkg per day
Illicit Substance/Drugs:_____
Use:_____per day_____per wk
Alcohol Use: _____per day_____per wk

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

Doctor Reviewed _____

PATIENT INFORMATION

NAME:_____BIRTHDATE:_____

ADDRESS:_____CITY_____, HI, ZIP CODE_____

HOME #:_____WORK/DAY#:_____CELL#:_____ ☐ Ok to text?

OCCUPATION_____EMPLOYER_____

EMAIL ADDRESS:_____

Medical Insurance_____**Vision Insurance**_____

Subscriber's Name _____ **Subscriber's Date of Birth**_____

How were you referred to us:_____

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to **Nora M.Y. Chan, 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-Revised January 2016):

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

********** ***FOR DOCTORS & STAFF USE*** **********

Exam Type: ☐ Vision 92_____ ☐ Medical _____ ☐ Refraction
☐Cataract Post Op 66984 Modifiers___55 ___Rt____Lt
Contact Lens Fitting: ☐ Existing wearer ☐ New Fit ☐ Medical Fit
Bandage Contact Lens Fitting ☐ 92071 **Corneal Topography** ☐ 92025
Epilation ☐67820 _____Lid(s) **FB removal** ☐ Cornea 65222
FB removal ☐Conjunctiva embedded 65210 ☐ superficial 65205
Gonio ☐ 92020 **OCT** ☐ Optic Nerve 92133 ☐ Retina 92134
Pachymetry☐76514 **Photo** ☐ Anterior 92285 ☐ Posterior 92250
Visual Fields ☐ 92083 ☐ other_____ **Other:**_____
CHARGES:

___**OM/INSURANCE info** updated__Screened
DFE 1 _____ **Appointment:** _____
2_____
☐ **Photos** _____ **Check-in:** _____
☐ **OCT** _____
☐ **FDT** _____ **Dr. Exam In:** _____
☐ **Fields** _____
Out: _____
☐ **Dispensed CL trials@** _____

Single Vision
☐ Distance ☐ Readers ☐ Computer/Intermediate
☐ Sunglasses ☐ Safety Glasses ☐ Optional
☐ Ocular fatigue (Eyezen/Sync)

Multifocal
☐ ST 28 ☐ ST 35 ☐ Trifocal ST___X___
☐ Progressive_____ ☐ Computer_____

MONOC PD DIST (OD)_____/(OS) _____

☐ **ORDERED** ☐ **NOT INTERESTED**

Material
☐ CR 39 ☐Trivex/Polycarb ☐ Mid Index ☐ High Index

Photo-chromatic
☐ Tint ☐ Solid ☐ Gradient ☐ BluTech
☐ Transitions ☐XTRActive ☐ Polaroid

Anti-Glare
☐Sapphire ☐ Prevencia ☐ Avance ☐ Other

Contact Lenses
ORDER: ☐Trials ☐ Final CLRx ☐ Call to finalize CLRx CL Solution: _____
☐**ORDERED** ☐ **NOT INTERESTED** ☐ CL Trials Scanned ☐ Please Scan Trials

☐ Referral to Specialist: _____
Diagnosis:_____
Appoint Date/Time:_____
☐ Letter to PCP _____
☐ Call Rx to Pharm. _____
Recommended product _____

☐ Next Visit_____
☐ Recheck Reason:_____
☐ pachymetry ☐ OCT ☐Photos ☐ Fields ☐ Gonio ☐clck/cld
☐ IOP ☐ Dilation ☐ Complete Eye Exam
Sample/Coupon for _____
Assistant _____