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
Okay to Text You? Yes No

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.

Your Symptoms:	**History of Eye 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			

Reason for todav's visit:

Women: Are you Pregnant ? Yes_ No Are you breast feeding? Yes No ___

****Office Use Only****

	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: _____/______ ______

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 Smkr
__ Current Smoker_____pkg per day
__ **Illicit Substance/Drugs Use:**_________per day_______per wk
Alcohol Use:_________per day_______per wk

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

Doctor Reviewed ___________

PATIENT INFORMATION

NAME:______________________________BIRTHDATE:______________

ADDRESS:____________________________CITY______________, HI, ZIP CODE______

HOME PHONE:________________ WORK/DAY PHONE:________________ CELL PHONE:________________ ☐ Ok to text?

OCCUPATION/EMPLOYER or GRADE/ SCHOOL__________________________/__________________________

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 ☐ Medical ☐ Done w/Specialty Testing
Contact Lens Fitting: ☐ New ☐ Medical ☐ Existing wearer
☐ Referral to Specialist: ____________________
Diagnosis:____________Appoint Date/Time:__________

☐ Next Visit__________☐ Recheck VA's, SLE, Ta
__pach ☐ Imaging/Photos ☐ Fields ☐ Gonio ☐ Complete Exam
☐ Call Rx to Pharm. ________________
Sample/Coupon for ______________

****

DFE:________time __________ **Appointment:**
☐ Photos_____ ___________ **Check-in:**
☐ OCT _____ ___________ **Dr Exam In:**
☐ FDT **Out:** __________
☐ Fields ___________
☐ Letter to PCP ____________________

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

Multifocal
☐ ST 28 ☐ ST 35 ☐ Trifocal ST____X___
☐ Progressive_________ ☐ Computer________

MONOC PD DIST (OD)________/(OS)_______

☐ CL Trials Scanned ☐ Please Scan trials

Material/Tint
☐ CR 39 ☐ Poly ☐ Mid Index ☐ High Index ______
☐ Trivex ☐ Gradient _______
☐ Tint ☐ Solid _______ ☐ BluTech

☐ XTRActive ☐ Polaroid_________

☐ AR________ ☐ Transitions_______

Contact Lenses
ORDER ☐ Trials ☐ Final CLRx ☐ Clck/Disp **APPT** _______
CL SOLUTIONS________________________________
Dispensed trials@

___**OM info** updated_______Screened
___**CHARGES** entered
- ☐ office visit, EXAM, CLck, CL exam
- ☐ Glasses, Contacts
- ☐ Special test: photos,OCT,VF,etc

___**PAYMENT** entered/___no payment, gave billing
PATIENT UNDERSTANDS BILLING ____

___PAs , AUTH nos, PCP referrals
___**VSP Vision/CLex sub'd**
___**Union claims**___sign'd/scan'd /mail'd
___**ORDERED** glasses/contacts
___**Pre appt made / Recall Entered**_______
___Call to finalize CLRx
Assistant __________________