KAUA'I
EYE INSTITUTE

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PATIENT INFORMATION Today's Date:___________________

Last Name: ____First Name:_______ ______________________________M or F

Name Preference:_____________________________DOB:________________SSN: _____________________________________

Address:____City____________________ST______Zip_______________

Phone Number:___________________________Email Address:____

Primary Care Physician:__________________________ Optometrist:_________________________ Height: _______Weight:________

Reason for Today's exam____

(Do not complete medical questionnaire below if you have already entered all pertinent information into your patient portal on kauaieye.ema.md)

Past medical history (list major medical problems, diagnoses): ____

____

____

Past surgical history (list any major surgeries): ____

____

Past ocular history (check):

☐ Cataract ☐ Glaucoma ☐ Pterygium ☐ Retinal Problems ☐ Macular degeneration ☐ Dry eyes ☐ Ocular allergies

☐ Other (list): ____

☐ Eye surgery (e.g. LASIK, cataract): ____

Preferred Pharmacy (Name, City): ____

Medications (list all medications being taken): ____

____

____ ☐ Check if you agree to allow sharing of information with pharmacy

Allergies (name medication and type of reaction): ____

____

Family history (check and write name of family member):

☐ Cataract __________ ☐ Glaucoma ___________ ☐ Retinal Problems ___________☐ Macular degeneration ___________

☐ Cancer ___________ ☐ Crossed eyes ____________ ☐ Other (list): ____

Social history:

Occupation: ____

Alcohol use (check): ☐ None ☐ Occasional (<1 drink/day) ☐ Daily (1-2 drinks/day) ☐ Moderate (3+ drinks/day)

Smoking (check): ☐ Never ☐ Former smoker (___ packs/day x ___ yrs) ☐ Current smoker (___ packs/day x ___ yrs)

Emergency contact: Name: ______________________ Phone: __________________ Relation to pt: ______________