Precision Vision

Dr. Dirk Fujii ~ Dr. Derrick Abe

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ DOB: _____ SSN# (last 4):_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email:_____

Employer (or School): _____ Occupation (or Grade): _____

Emergency Contact: _____ Relationship: _____ Ph#: _____

Medical Doctor: _____ Last Medical Exam: _____ Referred By:_____

Preferred Pharmacy: _____

Insurance Information **(Write "None" if no insurance)**

	Company	Subscriber	Membership #
Primary Vision Insurance	_____	_____	_____
Second Vision Insurance	_____	_____	_____
Primary Medical Insurance	_____	_____	_____
Second Medical Insurance	_____	_____	_____

Do you have any drug allergies? Yes ☐ No ☐ If yes, please list: _____

List any medication you take (including aspirin, OTC, eye drops, etc.): _____

_____

List all major injuries, surgeries, hospitalizations: _____

Have you ever had any Eye Disease, Eye Injury, or Eye Surgery? Yes ☐ No ☐ *(If yes, Please describe)*

_____

Do you wear glasses? Yes ☐ No ☐ If yes, how old are your current glasses? _____

Do you wear contact lenses? Yes ☐ No ☐ If no, are you interested in wearing contact lenses? Yes ☐ No ☐ Maybe ☐

What type (Brand, Base Curve, Diameter, Power)? _____

How often do you replace your lenses? _____ Contact lens solution: _____

How often do you wear your contacts? _____hrs/day _____days/week

Social History

This information is kept strictly confidential; however, you may discuss this portion directly with the doctor if you prefer.

Do you drive? Yes ☐ No ☐ If yes, do you have visual difficulty when driving? Yes ☐ No ☐ If yes, please describe

_____

Do you use tobacco products? Yes ☐ No ☐ If yes, type/amount/how long? _____

Do you drink alcohol? Yes ☐ No ☐ If yes, type/amount/how long? _____

Do you use illegal drugs? Yes ☐ No ☐ If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐

Review of Systems

Do You Have Any Of The Following Problems/Conditions (Please List):

YES NO

☐ ☐ Allergy (*Hay Fever, Atopy, etc.)* _____

☐ ☐ Cardiovascular (*High Blood Pressure, Cholesterol, etc*) _____

☐ ☐ Constitutional (*Fever, Weight Loss/Gain, Fatigue, etc*) _____

☐ ☐ Endocrine (*Diabetes, Hormone, Thyroid, etc*) _____ If Diabetes: Type I or II

☐ ☐ Gastrointestinal (*Hernia, Ulcers, Acid reflux, etc*) _____

☐ ☐ Genitourinary (*Bladder infection, kidney stones, Prostate, etc*) _____

☐ ☐ Head (*Hearing Loss, Cough, Congestion, Dry mouth, etc*) _____

☐ ☐ Hematologic/Lymphatic (*Anemia, Blood Disorder, Bleeding Problems etc*) _____

☐ ☐ Integumentary (*Skin, Rashes, Acne, Eczema,etc*) _____

☐ ☐ Musculoskeletal (*Arthritis, Joint, Osteoporosis, etc*) _____

☐ ☐ Neurological *(Multiple Sclerosis, Headaches, Migraines, etc*) _____

☐ ☐ Psychiatric (*Anxiety, Depression, ADHD, Bi-Polar, etc*) _____

☐ ☐ Respiratory (*Asthma, Emphysema, Bronchitis, Etc*) _____

☐ ☐ Currently Pregnant/Nursing

Eyes	**Yes**	**No**	**Not Sure**		**Yes**	**No**	**Not Sure**
Loss of vision	☐	☐	☐	Sandy or Gritty Feeling	☐	☐	☐
Blurred Vision	☐	☐	☐	Itching	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Burning	☐	☐	☐
Loss of side vision	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Double vision	☐	☐	☐	Excess Tearing/Watering	☐	☐	☐
Dryness	☐	☐	☐	Glare/Light Sensitivity	☐	☐	☐
Mucous Discharge	☐	☐	☐	Eye Pain or Soreness	☐	☐	☐
Redness	☐	☐	☐	Chronic Infection of Eye/Lid	☐	☐	☐
Chronic Infection of Eye/Lid	☐	☐	☐	Flashes/Floaters in Vision	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Tired Eyes	☐	☐	☐

Family History

Please note any family history (parents, maternal/paternal grandparents, siblings; living or deceased) for the following conditions:

Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

I authorize the release of any medical information necessary to process any claims(s) to my insurance company, social security administration, or any of the above named insurances. I request all payments under the insurance program be made to me or to the provider for services and materials furnished to me during the effective period of this authorization. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred and in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

Patient's Signature _____ Date _____