

**GENERAL PATIENT INFORMATION**

Gender: M/F Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Primary: home/cell/work  
 SSN \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 E-mail \_\_\_\_\_ Vision Insurance Company \_\_\_\_\_  
 In case of emergency, contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Referred by \_\_\_\_\_

By signing below, I understand that I am financially responsible for any charges not covered by my insurance. It is my responsibility for knowing what vision insurance I have, and whether or not Dr. Kevin K. Hirano is a covered doctor under my plan. I also understand that if I am unaware of what insurance company I am covered under, I may be responsible for payment in full at the time services are rendered.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HEALTH HISTORY**

1. Do you or have you ever had any serious EYE HEALTH related problems (injuries, surgeries, or diseases)? YES/NO. If yes, please explain: \_\_\_\_\_

2. Have you ever experienced any of the following (under normal vision conditions): bright flashes of light in your vision? YES/NO. Small spots or lines floating through your vision? YES / NO. Any other unusual symptoms? YES/NO. If yes, please explain: \_\_\_\_\_

3. Do you have any general health related issues (diabetes, diabetic retinopathy, high blood pressure, high cholesterol, etc.)? YES/NO. If yes, please list: \_\_\_\_\_

4. Are you currently taking any prescription or non-prescription medication? YES/NO. If yes, please list each medication and reason for taking: \_\_\_\_\_

5. Do you have any allergies to medication? YES/NO. If yes, please list: \_\_\_\_\_

6. Do you have seasonal allergies? YES/NO.

7. Female, are you pregnant? YES/NO. Breastfeeding? YES/NO

8. Do you smoke? YES/NO.

9. Is there any FAMILY (blood related) history of any of the following eye health problems? Please check all that apply and list their relationship to you:

YES	NO		Relationship to you	
_____	_____	Glaucoma	_____	
_____	_____	Cataracts	_____	
_____	_____	Retinal tear/detachment	_____	
_____	_____	Macular Degeneration	_____	
_____	_____	Other: _____	_____	

**Date Reviewed/Initials:**