LASIK AT ISLAND EYE SPECIALISTS

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PATIENT INFORMATION

CHART#: _____

NAME: Last First MI	DOB: / / MM DD YY	AGE:	SEX: M / F
SSN: - -	EMPLOYER:	OCCUPATION:	
EMAIL ADDRESS:	**HOW DID YOU HEAR ABOUT US?**	☐ SUPERBOWL AD ☐ KUAM NEWS ☐ MCV CH.09 ☐ FACEBOOK ☐PDN ☐ RADIO ☐ ITC /TUMON BIG SCREEN ☐REFERRAL: _____	

MAILING ADDRESS: _____ (Street)

☐Yes, I would like to receive news, updates and information at this address.

_____

_____ (City, State) _____ (Zip)

CONTACT #'S:
☐ _____ HOME
☑ Please indicate your preferred contact number(s)
☐ _____ CELL
☐ _____ OTHER

INSURANCE PROVIDER: ☐CALVOS ☐TAKECARE ☐NETCARE ☐MEDICAID ☐MIP ☐STAYWELL ☐OTHER:

EYE/MEDICAL HISTORY (PLEASE ANSWER THE FOLLOWING PORTION AS ACCURATELY AS POSSIBLE)

1. **DO YOU WEAR**: ❑GLASSES ❑CONTACTS → __SOFT CONTACTS __HARD CONTACTS __EXTENDED WEAR __TORIC (_____)

2. **LAST EYE EXAM**: _____ (DATE OR TIME FRAME) WITH DR._____ (NAME OF DOCTOR/OPTOMETRIST) AT_____ (CLINIC). MAY WE VERIFY? ❑YES

3. **HOW OLD IS YOUR CURRENT PRESCRIPTION?** _____ (DAYS, MONTHS, YEARS)

4. **HAS YOUR PRESCRIPTION CHANGED WITHIN THE PAST YEAR?** ❑NO ❑YES ❑NOT SURE

5. **ARE YOU <u>CURRENTLY</u> EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK ALL THAT APPLY.**
   ❑Pressure Pain ❑Sandy Sensation ❑Throbbing ❑Eyelid Crusting ❑Excessive Tearing ❑Redness
   ❑Floaters ❑Mucous Discharge ❑Light Sensitivity ❑Flashing Lights ❑Itchiness ❑Halos
   ❑Double Vision ❑Loss of Vision ❑Blurry Vision ❑Dryness ❑Burning Sensation

6. **HAVE YOU HAD ANY EYE INJURIES?** ❑ NO ❑YES: _____

_____

7. **HAVE YOU HAD ANY EYE SURGERY OR LASER TREATMENTS?** ❑ NO ❑YES: If so please list type, which eye, and when

_____

_____

8. **ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS? PLEASE CHECK ALL THAT APPLY:**
   ❑DIABETES ❑ HEART DISEASE ❑HYPERTENSION ❑HIGH CHOLESTEROL ❑STROKE ❑ARTHRITIS ❑LUPUS
   ❑ THYROID DISEASE ❑ ANEMIA ❑KIDNEY DISEASE ❑TUBERCULOSIS ❑ CANCER ❑ASTHMA

OTHER: _____

9. **ARE YOU CURRENTLY USING ANY MEDICATIONS? PLEASE LIST NAME AND INSTRUCTIONS**: _____

_____

10. **DO YOU HAVE ANY MEDICATION/FOOD/DRUG ALLERGIES? ☐YES ☐ NO IF SO, PLEASE LIST TYPE AND REACTIONS:**

_____

_____

11. **DOES ANY FAMILY MEMBER(S) HAVE A HISTORY OF ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:**
    ❑DIABETIC RETINOPATHY ❑GLAUCOMA ❑CATARACT ❑RETINAL DETACHMENT ❑ BLINDNESS ❑RETINAL DISEASE
    ❑MACULAR DEGENERATION ❑LAZY EYE ❑ LUPUS ❑ARTHRITIS ❑SJOGREN'S SYNDROME

_____ **PRINT NAME** _____ **SIGNATURE** _____ **DATE**