Patient HEALTH History

Dr. Gerald M. Matsuda **Dr. Stuart K. Machida** **Dr. Kari J.Y. Chang-Moses**

Name

Reason For Visit : ☐ Check Up *(No Difficulty, Seeing Clearly And Comfortably)*
☐ Seeing Or Eye Problem *(Please Explain)* ______

How Long Ago Was Your Last Complete Eye Exam? ______ Dilated ☐ Yes ☐ No
Who Was Your Last Eye Doctor? ______ Who Is Your Primary Care Physician? ______
Do You Wear Glasses? ☐ Yes ☐ No How Old Are Your Present Glasses? ______

Have You Ever Worn Contact Lenses? ☐ Yes ☐ No
Do You Currently Wear Contact Lenses? ☐ Yes ☐ No ☐ Sometimes
State Contact Lens Type (Brand, Base Curve, Diameter, Power) ______
If No, Are You Interested In Wearing Contact Lenses? ☐ Yes ☐ No ☐ Maybe

Are You Currently Taking Any Drugs Or Medications?
☐ Yes ☐ No *(If Yes, please list)*

Are You Allergic To Any Drugs Or Medications?
☐ Yes ☐ No *(If Yes, please list)*

Have You Ever Had Any Eye Disease, Eye Injury, Or Eye Surgery? ☐ Yes ☐ No *(If Yes, please describe)*

Do You Currently Smoke? ☐ Yes ☐ No Have You Ever Smoked Before? ☐ Yes ☐ No Height ______
Do You Drink Alcohol? ☐ Yes ☐ No Do You Use Recreational Drugs? ☐ Yes ☐ No Weight ______

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

YES	NO	
☐	☐	Allergy *(Hay Fever, Atopy, Etc.)* ______
☐	☐	Cardiovascular *(High Blood Pressure, Cholesterol, Heart Problems, 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 (Ears, Nose, Mouth, Throat) *(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

Do You Have Any Family History Of: *(Please List Family Member)*

Amblyopia ______
Blindness ______
Cataracts ______
Eye Surgery ______
Glaucoma ______
Macular Degeneration ______
Other Eye Problems ______

Diabetes ______
High Blood Pressure ______
High Cholesterol ______
Cancer ______
Other ______

I ACKNOWLEDGE THAT I RECEIVED A COPY OF WINDWARD VISION CENTER'S NOTICE OF PRIVACY PRACTICES.

______ Signature ______ Date

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