

Welcome to our office! Dr. Iida and staff thank you for entrusting us with your visual care needs. Your satisfaction and eye health are very important to us. If you have any questions, please don't hesitate to ask for assistance. Mahalo!

| Today's Date Last First | Patient Information |
|--|---|
| Last | Today's Date |
| Date of Birth | Last |
| Date of Birth | First MI |
| Street | Date of Birth Age |
| Street | Gender M F Email Address |
| Home Phone | Street |
| Home Phone | CityState Zip Code |
| Home Phone Patient's SSN Employer (or School) Occupation (or Grade) Hobby/Recreation Marital status Spouse (or Parent's Name) Spouse (or Parent's Work) Emergency contact: Name/Relationship Phone Email What is the major purpose of this visit? Any problems with your current contact lenses or glasses? VERY IMPORTANT! NEW PATIENTS ONLY: Who may we thank for referring you to our office? Name of friend or relative If not referred, how did you choose our office? Another Dr. Insurance List Saw Sign/Building Newspaper/Radio/TV Yelp Web Page: Which Web Site? | Cell Phone |
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| Hobby/Recreation | Occupation (or Grade) |
| Marital status | Hobby/Recreation |
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| □ Newspaper/Radio/TV □ Yelp □ Web Page: Which Web Site? | |
| ☐ Yelp ☐ Web Page: Which Web Site? | |
| ☐ Web Page: Which Web Site? | |
| □ Other | |
| | □ Other |

| Insurance Inf | ormation |
|---|----------------------------|
| Vision Insurance | |
| Subscriber Name | |
| Subscriber SSN_ | |
| Subscriber Birth Date_ | |
| | |
| Primary Medical Insurance | |
| Subscriber Name | |
| Subscriber SSN_ | |
| Subscriber Birth Date | |
| Do you participate in a flex spend | ing account? |
| How will you settle your account | |
| □ Cash □ Che | ck Credit Card |
| | |
| | |
| Lifestyle Qu | |
| Do you(check box if your a | |
| work long hours at a computer | |
| think you might benefit from t | |
| □have interest in a "test drive" o | of the latest contact lens |
| designs | 10 77 / 1 |
| spend time outdoors? How mu | |
| have prescription sun wear or | |
| prefer not to wear your glasses | |
| want information on Laser Vis | 0 1 |
| □have more than 1 pair of curre □have children? | nt Kx eyewear? |
| have family members in need | of avacara? |
| have a history of eye surgery? | - |
| | Type |
| Have you ever experienced, bee | n diagnosed or treated for |
| any of the following? | |
| ☐ Blurry Vision | ☐ Burning |
| ☐ Cataracts | □ Corneal Abrasions |
| □ Crossed eye/Eye turn | □ Double Vision |
| ☐ Eye Infections | ☐ Eye Injury |
| ☐ Flash of light | ☐ Floaters/Spots |
| ☐ Glaucoma | ☐ Grittiness |
| ☐ Headaches | ☐ Iritis/Uveitis |
| ☐ Itchiness | ☐ Lazy Eye |
| ☐ Macular Degeneration | ☐ Occasional dryness |
| Retinal Detachment | ☐ Sunlight Sensitivity |
| □ Tearing | ☐ Trouble seeing at night |
| ☐ Uncomfortable glasses | ☐ Other |



The information in this confidential case history form is

| Patient Medical His | story | | Patient Eye History | |
|--|----------|---------------|---|--------|
| Name of Family Physician | | | Date of Last Eye ExamDilated? | |
| City | | | By Whom? | |
| Date of Last Physical Check-up | | | | |
| | | | Have you ever tried contact lenses? ☐ Yes ☐ No | |
| CURRENT MEDICATIONS (Rx or | | | Do you currently wear contact lenses? ☐ Yes ☐ No | |
| (List name of medications including ey | e drops, | vitamins, & | What kind? | |
| birth control pills) | | | Is it for astigmatism, multifocal, monovision? \Box Yes \Box | No |
| Allergies to medications? | □ Yes | □ No | Are you satisfied with the vision and comfort of your | |
| If so, what medications? | | | contact lenses? ☐ Yes ☐ No | |
| | | | How many hours do you wear your contact lenses? | |
| Have you had any surgeries? | | | How often do you replace your contact lenses? | |
| Type of surgery | | | Do you sleep in your contact lenses? | |
| Type of surgery | or other | r substances? | □ Yes □ No | |
| □ Yes | □ No | | | |
| | | | If you wear bifocals, do the lines or head tilting bother | you? |
| Have you ever been diagnosed or trea | | | □ Yes □ No | |
| following health problems? | Yes | No | | |
| Arthritis | | | Family Medical/Eye History (Check all that app | oly) |
| Asthma | | | | |
| Atrial fibrillation | | | Is there a family medical history of any of the following | g: |
| Cerebrovascular accident | | | | |
| Chronic obstructive lung disease | | | Relationship | |
| Diabetes | | | (Mother's or Father's side) | |
| End-stage renal disease | | | Blindness Cancer | |
| Epilepsy | | | Cataracts Diabetes | |
| GERD | | | Glaucoma Heart Disease | |
| High Blood Pressure | | | High blood pressure Macular Degeneration | |
| High cholesterol | | | Stroke Thyroid | |
| HIV | | | | |
| Hyperthyroidism | | | | |
| Hypothyroidism | | | I authorize Makana Vision to release any informa | ation |
| Inflammatory disease of liver | | | including the diagnosis and the records of any treatme | |
| Leukemia | | | examination rendered to me or my child during the p | |
| Malignant lymphoma | | | of such eye care to a third party payer and/or h | |
| Malignant tumor of breast | | | practitioner. | |
| Malignant tumor of colon | | | | |
| Malignant tumor of lung | | | I understand that all applicable copayments and deduct | tibles |
| Malignant tumor of prostate | | | are due at the time of service.I authorize and reques | |
| Radiation therapy treatment | | | insurance company to remit payment directly to Ma | |
| Transplantation of bone marrow | | | Vision otherwise payable to me. I understand that my | |
| Other | | | care insurance carrier(s) may pay less than the actua | _ |
| | | | for services and I agree to be responsible for payment | |

| Patient Eye History | | | | |
|---|--|--|--|--|
| Date of Last Eye Exa | | | | |
| By Whom? | | | | |
| Have you ever tried | | | | |
| Do you currently we What kind? | | | | |
| Is it for astigmatism, | , multifocal, mon | ovision? □ Yes □ No | | |
| Are you satisfied wit | | | | |
| contact lenses? | □ Yes | □ No | | |
| How many hours do | you wear your co | ontact lenses? | | |
| How often do you re | place your conta | ct lenses? | | |
| Do you sleep in your | r contact lenses? | | | |
| | \square Yes | □ No | | |
| If you wear bifocals, | do the lines or h | ead tilting bother you? | | |
| | □ Yes | □ No | | |
| Family Medical/E | Evo History (Cl | hock all that annly) | | |
| r anning inicalcant | Eye History (Ci | neck an that apply) | | |
| Is there a family med | | | | |
| | | ny of the following: | | |
| | dical history of ar | ny of the following: | | |
| Is there a family med | dical history of ar | ny of the following: | | |
| Is there a family med (Mother's or Father' | dical history of ar Relationship s side) | ny of the following: | | |
| Is there a family med (Mother's or Father' Blindness | dical history of an Relationship s side) Cano | ny of the following: | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma | dical history of an Relationship s side) Cano Diab | ny of the following: | | |
| Is there a family med (Mother's or Father' Blindness Cataracts | dical history of an Relationship s side) Cano Diab | ny of the following: cer petes rt Disease ular Degeneration | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure | Relationship s side) Canc Diab Hear | ny of the following: cer petes rt Disease ular Degeneration | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke | Relationship s side) | ny of the following: cer petes rt Disease ular Degeneration roid cease any information | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagno | dical history of an Relationship s side) Cano Diab Hear Mac Thyr | ny of the following: cer petes rt Disease ular Degeneration roid ease any information rds of any treatment of | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagno | dical history of an Relationship s side) Cano Diab Hear Mac Thyr | ny of the following: cer petes rt Disease ular Degeneration roid ease any information rds of any treatment of | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagnot examination rendere | Relationship s side) Cancello Diabello Hear Macello Thyresis and the recorded to me or my control of the side of | ny of the following: cer betes rt Disease ular Degeneration roid ease any information rds of any treatment of child during the period | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagnor examination rendere | Relationship s side) Cancello Diabello Hear Macello Thyresis and the recorded to me or my control of the side of | ny of the following: cer betes rt Disease ular Degeneration roid ease any information rds of any treatment of child during the period | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagnor examination rendere of such eye care | Relationship s side) Cancello Diabello Hear Macello Thyresis and the recorded to me or my control of the side of | ny of the following: cer petes rt Disease ular Degeneration | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagnor examination rendere of such eye care in | Relationship s side) | ny of the following: cer betes rt Disease ular Degeneration roid ease any information rds of any treatment of child during the period | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagnor examination rendere of such eye care in practitioner. | Relationship s side) | ny of the following: cer petes rt Disease ular Degeneration roid ease any information rds of any treatment of child during the period y payer and/or health | | |
| Is there a family med (Mother's or Father' Blindness Cataracts Glaucoma High blood pressure Stroke I authorize Makana including the diagnor examination rendere of such eye care in practitioner. I understand that all are due at the time | Relationship s side) Canc Diab Hear Macc Thyr a Vision to releasis and the record to me or my of to a third party applicable copay of service. I auti | ny of the following: cer petes petes ular Disease ular Degeneration roid ease any information rds of any treatment of child during the period payer and/or health | | |

services rendered on my behalf or my dependents.

Date