RETINA CONSULTANTS OF HAWAII

GREGG T. KOKAME, MD - JAMES C. LAI, MD
SARAH P. READ, MD, PHD- RAYMOND WEE, MD
Excellence through Compassionate Clinical Care and State of the Art Research

PATIENT NAME: _____BIRTHDATE: ____/____/____ DATE: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING YOUR MEDICAL HEALTH HISTORY:

Allergies/Reaction: ☐No ☐Yes _____ Latex Allergy? ☐ No ☐ Yes

What pharmacy would you like to use if the doctor prescribes you medication?

Name: _____

Phone: _____

List your current medical doctors and phone numbers.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

PATIENT MEDICAL HISTORY: Please check all that apply to you.

Cardiovascular:	**Renal Disease:**	**Rheumatology:**
☐Heart Attack- **Date:**	☐Kidney Failure	☐History of Plaquenil Use
☐High Blood Pressure	☐Dialysis	☐Rheumatoid Arthritis
☐Heart Murmur	☐Urinary Infections	☐Lupus
☐Atrial Fibrillation	☐Kidney Stones	☐Sjogren's Syndrome
☐Irregular Heartbeat	**Gastrointestinal:**	**Immunodeficient:**
☐Mitral Valve Prolapse	☐GERD	☐HIV
Pulmonary Disease:	☐Inflammatory Bowel Disease	☐Tuberculosis
☐Asthma	**Oncology:**	☐Hepatitis B
☐Emphysema	☐Cancer-**Type:**	**HEENT:**
☐COPD	☐Anemia	☐Hearing Loss
Endocrine:	☐Blood Transfusions	☐Sleep Apnea ☐CPAP
☐Diabetes Type 1	**Neurological:**	☐Sinus Problems
☐Diabetes Type 2	☐Stroke- **Date:**	**Musculoskeletal:**
Age Diagnosed with Diabetes:	☐Migraines	☐Osteoporosis
☐Thyroid Disease	☐Dementia	☐Arthritis
☐High Cholesterol	☐Alzheimer's	**Other:**

Have you received your pneumococcal vaccine? ☐No ☐ Yes ☐ Unknown

Have you received your influenza immunization this year? ☐No ☐ Yes ☐ Unknown

DIABETIC PATIENTS: Dialysis: ☐ No ☐ Yes - ☐M/W/F or ☐T/Th/F Last Blood Sugar Level: _____ Last HA1c_____

FEMALE PATIENTS: Are you pregnant? ☐ No ☐ Yes - How many weeks? _____ Due Date: _____ Nursing? ☐ No ☐ Yes

List all surgeries you have had. Include all eye surgeries and dates.

1.)	DATE:	6.)	DATE:
2.)	DATE:	7.)	DATE:
3.)	DATE:	8.)	DATE:
4.)	DATE:	9.)	DATE:
5.)	DATE:	10.)	DATE:

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List all your current medications/supplements you are taking. (Include Eye Drops) (Name, Dosage, Frequency):

1.)	6.)
2.)	7.)
3.)	8.)
4.)	9.)
5.)	10.)

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING YOUR SOCIAL/FAMILY HISTORY:

Medical Condition:	**Family:**							
Please check all that apply.	Mother	Father	Brother	Sister	Aunt	Uncle	Grand-Mother	Grand-Father
Retinal Detachment								
Macular Degeneration								
Glaucoma								
Retinitis Pigmentosa								
Diabetes								
Hypertension								
Cancer								
Other:								

Marital Status:
☐Single ☐Partner ☐Married
☐Separated ☐Divorced ☐Widowed

Do you smoke? ☐No ☐ Yes
If so, how much? _____

Do you drink alcohol? ☐No ☐ Yes
If so, how much? _____

Past and present drug use (legal or illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this: ☐No ☐ Yes

Do you drive? ☐No ☐ Yes

Current Occupation:
_____

Have you ever lived outside of Hawaii? ☐No ☐ Yes
If yes, where? _____

Have you ever had a blood transfusion since 1977?
☐No ☐ Yes

Living condition? ☐ Alone ☐With Family
☐Care home/Caretaker

Race*(Optional)*:
☐White ☐Black or African American
☐American Indian or Alaska Native
☐Native Hawaiian or Pacific Islander
☐Asian, specify: _____
☐Other, specify: _____

Ethnicity*(Optional)*:
☐ Latino/Hispanic ☐ Non-Latino/Non-Hispanic

Is there anything not mentioned on this form that you would like the doctors to be aware of?

_____

Your eyes will be dilated for your exam. Dilation will make the pupils of your eyes large for several hours and can cause *light sensitivity, glare, and blurred vision*. Dark glasses are recommended. If you do not have your own, please inform us.

Patient's Signature: _____ Date: _____

M.D Initials: _____