



Izumi Yamamoto, MD
 Hawaii Eye Clinic, Inc.
 1441 Kapiolani Blvd., Suite 1910
 Honolulu, HI 96814
 Tel: (808) 943-7000

Confidential Information

SECTION 1: TELL US ABOUT YOURSELF / ご本人情報

Patient Name: Mr. Mrs.
 Ms. Dr. _____
Last First MI Nickname

*Address: _____

City, State, Zip: _____

*Date of Birth: _____ Male Female *Social Security No.: _____

*Cell Phone: () _____ - _____ *Email: _____

Work Phone: () _____ - _____ Home Phone: () _____ - _____

Employer: _____

Marital Status: Married Single Divorced Widowed

Ethnicity: Japanese Caucasian Chinese Korean Filipino African American Hispanic Mix

Preferred Language: English Japanese

SECTION 2: INSURANCE INFORMATION (Copy Required) / 保険情報

Primary Insurance

Insurance Company: _____ Self Dependant

Subscriber's Name: _____ Subscriber's DOB: _____

Relationship: _____

Secondary Insurance

Insurance Company: _____ Self Dependant

Subscriber's Name: _____ Subscriber's DOB: _____

Relationship: _____

SECTION 3: EMERGENCY CONTACT / 緊急連絡先

Name: _____ Relationship: _____

Primary Phone: () _____ - _____ Cell Phone: () _____ - _____

Work Phone: () _____ - _____

SECTION 4: RESPONSIBLE PARTY (if different from yourself)/未成年者などで、患者ご本人と支払い責任者が違う場合

Name: Mr. Mrs.
 Ms. Dr. _____
Last First MI

Address: _____

City, State, Zip: _____

Date of Birth: _____ Male Female Social Security No.: _____

Relationship: _____

Primary Phone: () _____ - _____ Cell Phone: () _____ - _____

Employer: _____ Occupation: _____

Work Phone: () _____ - _____ Ext _____

SECTION 5: AUTHORIZATION FOR RELEASE (If you would like us to discuss your confidential medical information with anybody else such as your children, please list)

I authorize release of confidential medical information to the following contact persons:

Name: _____ Name: _____

Primary Phone: () _____ - _____ Primary Phone: () _____ - _____

Relationship: _____ Relationship: _____

I hereby authorize Izumi Yamamoto, M.D. or her representative to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I assign my insurance benefits including Medicare, HMSA and or any other health insurance plan payable to Hawaii Eye Clinic, Inc. The assignment will remain in effect unless revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance.

私はここに、ハワイアイクリニック, Inc.、山本いづみ, M.D. またはその代理人が、私の保険会社またはその代理人に対し、医療機密情報の開示をすることを承諾する。医療機密情報とは、このクリニックにておいて行われた検査や診察、診断内容、内科的あるいは外科的治療の内容、あるいは、保険請求に必要な個人情報を含む。私は Medicare など公的健康保険、HMSA など私的健康保険の受取りをハワイアイクリニック, inc.に譲渡し、保険機関からの支払いが直接ハワイアイクリニック, inc.へいくことを承諾する。この保険支払いの譲渡は私が書面によって通知するまで有効である。保険機関の支払いの有無にかかわらず、私がハワイアイクリニック, Inc. で受けた医療費すべてに支払い責任があることを承諾する。

Signature of Patient/Legal Guardian: _____ Date: _____



Izumi Yamamoto, MD
 Hawaii Eye Clinic, Inc.
 1441 Kapiolani Blvd., Suite 1910
 Honolulu, HI 96814
 Tel: (808) 943-7000

Confidential Patient History/病歴に関する質問書

Name/お名前: Mr. Mrs.
 Ms. Dr. _____
Last/姓 First/名 MI

Occupation/職業: _____ Hobbies/ご趣味: _____

Referred by/紹介者: _____ Primary Care Dr./主治医: _____

Radio TV Commercial Newspaper/Magazines Website Friends and Family

SECTION 1: EYE HISTORY/眼に関する病歴

Reason for visit/来院理由: _____

Do you wear glasses?/メガネをかけていますか?: No Yes
 for distance/遠くを見る用 for computer/コンピューター用 for near/近く用

Do you wear contact lenses/コンタクトは使いますか? No Yes

Do you have the following eye problems?/眼に関して以下の症状または病歴がありますか?

Tired eyes/眼が疲れる	<input type="checkbox"/> N <input type="checkbox"/> Y	Dry Eyes/ドライアイ	<input type="checkbox"/> N <input type="checkbox"/> Y
Eye pain, Redness/眼が痛い、赤目	<input type="checkbox"/> N <input type="checkbox"/> Y	Cataract/白内障	<input type="checkbox"/> N <input type="checkbox"/> Y
Eye discharge, Tearing/目やに、涙目	<input type="checkbox"/> N <input type="checkbox"/> Y	Glaucoma/緑内障	<input type="checkbox"/> N <input type="checkbox"/> Y
Itching, Sandy sensation/かゆみ、ごろごろ	<input type="checkbox"/> N <input type="checkbox"/> Y	Diabetes/糖尿病	<input type="checkbox"/> N <input type="checkbox"/> Y
Difficulty reading/本が読みにくい	<input type="checkbox"/> N <input type="checkbox"/> Y	Lazy eye/斜視、弱視	<input type="checkbox"/> N <input type="checkbox"/> Y
Difficulty driving/車の運転がしづらい	<input type="checkbox"/> N <input type="checkbox"/> Y	Macular degeneration/黄斑変性症	<input type="checkbox"/> N <input type="checkbox"/> Y
Light sensitive, Glare/光がまぶしい	<input type="checkbox"/> N <input type="checkbox"/> Y	Retinal detachment/網膜はく離	<input type="checkbox"/> N <input type="checkbox"/> Y
Floaters/浮遊物が見える	<input type="checkbox"/> N <input type="checkbox"/> Y	Swollen lids/まぶたが腫れる	<input type="checkbox"/> N <input type="checkbox"/> Y
Flashing lights/光がちらつく、閃光	<input type="checkbox"/> N <input type="checkbox"/> Y	Droopy eyelids/まぶたが垂れる	<input type="checkbox"/> N <input type="checkbox"/> Y
Double vision/物が二重に見える	<input type="checkbox"/> N <input type="checkbox"/> Y	Eye trauma/眼の外傷	<input type="checkbox"/> N <input type="checkbox"/> Y

Other/その他: _____

Have you had eye surgery or laser treatment?/眼の手術やレーザー治療を受けたことはありますか?

Cataract surgery /白内障手術	<input type="checkbox"/> N <input type="checkbox"/> Y	LASIK,PRK/レーシック	<input type="checkbox"/> N <input type="checkbox"/> Y
Glaucoma surgery/緑内障手術	<input type="checkbox"/> N <input type="checkbox"/> Y	Glaucoma laser/緑内障レーザー	<input type="checkbox"/> N <input type="checkbox"/> Y
Eye muscle surgery/斜視の手術	<input type="checkbox"/> N <input type="checkbox"/> Y	Diabetes laser/糖尿病網膜レーザー	<input type="checkbox"/> N <input type="checkbox"/> Y
Retinal detachment/網膜はく離の手術	<input type="checkbox"/> N <input type="checkbox"/> Y	Other laser/その他のレーザー	<input type="checkbox"/> N <input type="checkbox"/> Y
Eyelid surgery/まぶたの手術	<input type="checkbox"/> N <input type="checkbox"/> Y	Intraocular Injection/眼内注射	<input type="checkbox"/> N <input type="checkbox"/> Y

Other/その他: _____

SECTION 2: MEDICAL HISTORY/病歴

Do you smoke?/タバコは吸いますか? No Yes _____ packs/day Used to smoke/昔吸っていた

Do you drink alcohol?/お酒は飲みますか? No Yes _____ per day

Allergy(Drugs, food, vog etc.)/アレルギー (薬、食品、火山灰他) : _____

Do you have health problems or following symptoms?/以下の病歴、または症状がありますか?

Diabetes/糖尿病	<input type="checkbox"/> N <input type="checkbox"/> Y	Thyroid problem/甲状腺異常	<input type="checkbox"/> N <input type="checkbox"/> Y
High blood pressure/高血圧	<input type="checkbox"/> N <input type="checkbox"/> Y	Prostate problem/前立腺疾患	<input type="checkbox"/> N <input type="checkbox"/> Y
High Cholesterol/高コレステロール	<input type="checkbox"/> N <input type="checkbox"/> Y	Arthritis, Joint pain/リュウマチ、関節痛	<input type="checkbox"/> N <input type="checkbox"/> Y
Heart attack, Chest pain/心臓病	<input type="checkbox"/> N <input type="checkbox"/> Y	Autoimmune disease/自己免疫不全	<input type="checkbox"/> N <input type="checkbox"/> Y
Stroke/脳梗塞	<input type="checkbox"/> N <input type="checkbox"/> Y	Asthma, Emphysema/喘息、気管支拡張	<input type="checkbox"/> N <input type="checkbox"/> Y
Headache/頭痛	<input type="checkbox"/> N <input type="checkbox"/> Y	Allergy/アレルギー症状	<input type="checkbox"/> N <input type="checkbox"/> Y

Other/その他: _____

SECTION 3: FAMILY EYE HISTORY/ご家族の目の病歴

Glaucoma/緑内障	<input type="checkbox"/> N <input type="checkbox"/> Y	Macular degeneration/黄斑変性症	<input type="checkbox"/> N <input type="checkbox"/> Y
Night blindness, Blindness/夜盲症、失明	<input type="checkbox"/> N <input type="checkbox"/> Y	Retinal detachment/網膜剥離	<input type="checkbox"/> N <input type="checkbox"/> Y
Lazy Eyes/斜視、弱視	<input type="checkbox"/> N <input type="checkbox"/> Y		

Other/その他: _____

SECTION 4: CURRENT MEDICATIONS/現在使われているお薬

EYE MEDICATIONS/点眼薬		
Name 名前	L or R 左右	How often 頻度

ORAL MEDICATION/内服薬	
Name 名前	How often 頻度



Dry Eye Questionnaires

ドライアイに関する質問書

Patient Name _____

Date _____

Have you been diagnosed with Dry Eye Disease?

今までにドライアイと診断されたことはありますか?

Yes No

Do you have any of the following symptoms?

以下のような症状はありますか?

No

On and off blurry vision/かすんで見える

Excessive tearing/涙目

Redness/目が赤い

Tired eyes/目が疲れる

Burning/目がしみる

Mucous or discharge/目やにが出る

Itching/目がかゆい

Feeling of sand in the eye/目に異物感

Light sensitivity/光を眩しく感じる

Contact lens discomfort/コンタクトの異物感

Any of these symptoms related to the following conditions?

そのような症状は以下のようなときに良く起こりますか?

No

Windy conditions when outside/風がよく吹いているとき

Low humidity (air conditioning, airplanes)/湿度が低いとき(飛行機、エアコンがかかった部屋)

While using computers, watching TV, reading/コンピューター、読書、テレビを見ているときなど

Do you use the following?/以下のようなものを使いますか?

No

Contact lens/コンタクトレンズ

Over the counter eye drops/市販の目薬 (人工の涙、目をすっきり白くする充血を取る薬、など)

Glaucoma eye drops/緑内障の目薬

Anti-allergy eye drops or allergy pills/アレルギー用の目薬あるいは飲み薬

Have you had 今までに以下のような手術をされたことはありますか?

No

Cataract surgery/白内障の手術

LASIK or PRK/視力矯正手術 (レーシック、PRK など)

Eyelid surgery/まぶたの手術 (二重まぶたの手術、まぶたを上げる手術)

I review this form and based on the information contained therein and other available clinical data, I suspect that this patient has Dry Eye Disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending physician: _____ (Izumi Yamamoto, MD)



Izumi Yamamoto, MD
Hawaii Eye Clinic, Inc.
1441 Kapiolani Blvd., Suite 1910
Honolulu, HI 96814
Tel: (808) 943-7000

Notice to Patient

1. Refraction charges

One of the most important parts of your eye exam today is refraction. This test helps determine whether you have refractive errors, such as nearsightedness, farsightedness, or astigmatism. Refraction helps the doctor determine the best possible visual acuity and function of your eye. Although **your comprehensive eye exam is covered by your medical plan**, refraction may or may not be a covered service depending on your medical insurance plans. Some medical plans consider refraction a “vision” service not a “medical” service. Our office fee for refraction is **\$47+tax**. We will bill your insurance company for all services rendered today including the refraction. If your insurance company does not pay for the refraction, the refraction fee will be collected in addition to any co-payment, coinsurance or deductible. If you have a vision plan, refraction will be covered under medical or vision plan. Please call your insurance company if you have a question regarding your plan’s coverage.

2. Fee for late cancellation and no-show

If you would like to cancel your appointment, please call us 24 hours in advance. A no-show or late-cancellation fee of **\$50+tax** may be assessed.

3. Fee for returned checks

\$30+tax will be assessed for all returned checks.

By signing this form, I acknowledge receipt of this notice.

Patient’s name (printed)

Signature (or legal guardian)

Date