



Last Name: _____ First Name: _____ MI: _____

DOB: _____ SS#: _____

☐ Male ☐ Female

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email: _____ Occupation: _____

Employer: _____ Work Phone: _____

Preferred Method of Contact: ☐ Home ☐ Work ☐ Mobile ☐ Email

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Other Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

PATIENT FINANCIAL OBLIGATION AGREEMENT: I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and provide payment for charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Worldster Lee MD LLC/Cataract and Vision Center of Hawaii LLC for services rendered. I authorize representatives of Worldster Lee M.D. LLC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

RELEASE OF INFORMATION: I hereby give permission to the person(s) listed below to receive information about the care of the above patient:

Name: _____ Relationship: _____

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ, UNDERSTAND, AND AGREE WITH THE APPOINTMENT DETAILS, BILLING PROCEDURES, NOTICE OF PRIVACY PRACTICES, AND PATIENT RESPONSIBILITIES FORM PROVIDED TO ME. I ATTEST ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient or Representative Signature: _____ Date: _____

Preferred Pharmacy: _____

Please list all of your medical providers:

Primary Care Physician/Internist: _____

Referring Doctor: _____ Specialty: _____ Phone: _____

Optometrist: _____ Phone: _____

Do you smoke? ☐ Yes ☐ No How much/often? _____

Do you drink alcohol? ☐ Yes ☐ No How much/often? _____

Do you have any allergies to medications? ☐ Yes ☐ No What medications? _____

Do you have any allergies to iodine/shellfish? ☐ Yes ☐ No

Do you have any allergies to latex? ☐ Yes ☐ No

EYE HISTORY

Do you have a history of:

Diabetic Retinopathy ☐ Yes ☐ No Treatment: _____

Macular Degeneration ☐ Yes ☐ No Treatment: _____

Retinal Detachment ☐ Yes ☐ No Treatment: _____

Glaucoma ☐ Yes ☐ No Treatment: _____

Cataracts ☐ Yes ☐ No Treatment: _____

Laser Surgery ☐ Yes ☐ No Treatment: _____

Other: _____ ☐ Yes ☐ No Treatment: _____

SURGICAL HISTORY

List all surgeries, treatments, procedures and implants you have had:

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____



MEDICAL HISTORY

Please check yes and provide the date of diagnosis for any medical problems you presently have or have had in the past, otherwise, check no.

Check here if none of the options below apply ☐

General

Weight loss ☐ Yes ☐ No _____
Lack of energy ☐ Yes ☐ No _____
Trouble sleeping ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Year Diagnosed

Eyes

Vision loss ☐ Yes ☐ No _____
Changes in vision ☐ Yes ☐ No _____
Eye pain ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Ears, Nose, Mouth & Throat

Hearing loss ☐ Yes ☐ No _____
Sinus problems ☐ Yes ☐ No _____
Infections ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Cardiovascular

Heart attack ☐ Yes ☐ No _____
High blood pressure ☐ Yes ☐ No _____
Heart murmur ☐ Yes ☐ No _____
Irregular heart beat ☐ Yes ☐ No _____
Mitral valve prolapse ☐ Yes ☐ No _____
Chest pain ☐ Yes ☐ No _____
Circulation problems ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Respiratory

Asthma ☐ Yes ☐ No _____
Bronchitis ☐ Yes ☐ No _____
Shortness of breath ☐ Yes ☐ No _____
Emphysema ☐ Yes ☐ No _____
Tuberculosis ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Gastrointestinal

Ulcers ☐ Yes ☐ No _____
Diverticulitis ☐ Yes ☐ No _____
Constipation ☐ Yes ☐ No _____
Hepatitis ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Genitourinary

Kidney infections ☐ Yes ☐ No _____
Urinary infections ☐ Yes ☐ No _____
Cancer ☐ Yes ☐ No _____
Prostate ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Year Diagnosed

Bones, Joints & Muscle

Osteoporosis ☐ Yes ☐ No _____
Arthritis ☐ Yes ☐ No _____
Muscle pain ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Integumentary

Keloid/scarring ☐ Yes ☐ No _____
Skin rash/sensitivity ☐ Yes ☐ No _____
Skin cancer ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Nervous System

Seizure ☐ Yes ☐ No _____
Stroke ☐ Yes ☐ No _____
Paralysis/weakness ☐ Yes ☐ No _____
Numbness ☐ Yes ☐ No _____
Migraines ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Endocrine System

Diabetes ☐ Yes ☐ No _____
Kidney dialysis ☐ Yes ☐ No _____
Thyroid ☐ Yes ☐ No _____
High cholesterol ☐ Yes ☐ No _____

Blood

Anemia ☐ Yes ☐ No _____
Excessive bleeding ☐ Yes ☐ No _____
Bruising ☐ Yes ☐ No _____
Clotting problems ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

Immunologic

Lupus ☐ Yes ☐ No _____
Rheumatoid arthritis ☐ Yes ☐ No _____
HIV ☐ Yes ☐ No _____
Other ☐ Yes ☐ No _____

MEDICATIONS

Please list all medications you are currently taking, including non-prescription medications and vitamins:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

FAMILY MEDICAL HISTORY

Have any members of your family (parents, siblings, grandparents) had any of the following medical problems:

If yes, please indicate who has the condition

| | |
|-----------------|--|
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Thyroid disease | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Stroke | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Hepatitis | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No _____ |

| | |
|---------------------|--|
| Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Heart disease | <input type="radio"/> Yes <input type="radio"/> No _____ |
| High blood pressure | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Kidney disease | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Other | <input type="radio"/> Yes <input type="radio"/> No _____ |

Have any members of your family (parents, siblings, grandparents) had any of the following eye problems:

| | |
|----------------------|--|
| Retinal detachment | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Diabetic retinopathy | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Macular degeneration | <input type="radio"/> Yes <input type="radio"/> No _____ |

| | |
|----------|--|
| Glaucoma | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Other | <input type="radio"/> Yes <input type="radio"/> No _____ |

Your eyes may be dilated for your eye exam. Dilation will make the pupils of your eyes large for several hours and can cause light sensitivity, glare and blurred vision, especially up close. Dark glasses are recommended. If you do not have your own please ask us for a pair.