OPHTHALMOLOGY

Date　　　　Year　　　Month　　　Day

Title	Ms/Miss/Mrs/Mr/Dr/Other	Date of Birth	/ /	M ・F ・O
Name	(First)　　　　(Last)			
Address	〒			
Contact	Phone(　　　)　　　－	Email:　　　　@		

◆How long have you had your symptoms?　Since　　Year　　month　　day

◆Which of your eye(s) have been affected?　☐Right　☐Left　☐Both

◆Please check all corressponding answer.

☐mucous discharge　☐tearing　☐gritty

☐blurred vision　☐red eye　☐eyestrain

☐black specks in my vision (eye floaters)　☐itching　☐dry eye

☐pain on the surface of my eye　☐pain in the back of my eye　☐swollen eyelid

☐something stuck in the eye　☐other ____________________

☐prescription for contact lenses　☐prescription for eyeglasses

◆Are you wearing prescribed contact lenses?

☐No　☐Yes　(Brand/Type: ______________________________)

◆If you have known your prescription for contact lenses, please give us details below.

(PWR:________DIA:________BC:________)

([Astigmatic lenses user only] AX/AXIS:________CY/CYL:_________)

◆Are you currently under medical treatment?

☐No　☐Yes　(diabetes ・high blood pressure ・heart disease ・arthritis ・allergic rhinitis ・other

◆Have your ever experienced an allergic reation due to medication or injetcion?

☐No　☐Yes　(Name of Medication: ______________________________)

◆Are you pegnant or is there a possibility of pregnancy?

☐No　☐Yes

Thank you for your coopreation.