Patient Information

Contact number : Home (- - -)

Name: _____ Cellphone (- - -)

Birth date: _____ Age: _____ Yrs. Male/ Female

Address: _____

_____

Mark all that apply with a check (✔) or ○

1, What and when did you start having symptoms?

When: today, ( )days ago, ( )weeks ago, ( )months ago, ( )years ago

What: Right eye Left eye both eyes

Symptoms Pain, Itchy, Redness, Puss, irritation, watery eyes, difficult with sight

Dry eyes, tired, blurry vision, impaired vision, double vision

Any other symptom:

2, Do you have a preference between glasses or contacts?

( ) No , ( ) Contacts , ( ) glasses

3, Have you visited another optometrist recently?

( ) No , ( ) Yes

If Yes, please state dates, office and reason:

4, Have you had laser surgery?

( ) No , ( ) Yes

If Yes, please state reason:

5, Do have any of the following illnesses?

Diabetes, High blood pressure, Hyperlipidemia, Kidney failure, Other

Are you on any medication?

( ) No , ( ) Yes

If other, please state:

6, Do you have any allergies?

( ) No , ( ) Yes

If Yes, please state:

7, Would you like to speak to a social worker / Consultant?

( ) No , ( ) Yes

If Yes, please state reason:

8, Where did you here about us?

Internet, Pamphlets, billboards, friend referral, other ( )