Questionnaire

Name_____

Please Check or fill in the appropriate boxes below.

What is the problem today? (Check all that apply.)

Red eyes	Dry eyes	I was advised by another clinic/hospital
Eye discharge	Regular check-up	
Eye pain	Blurred vision	Eye grass prescription
Swelling	Glaring	Contact Lens Prescription
Itchiness	Floaters in vision	Is this your first pair of glasses or CL?
その他 ：		(Yes No)

- Where are you experiencing the symptom you are here for? Right eye Left eye Both eyes
- When did the symptom start? (　　)
- Are you, or have you been, under the care of an Ophthalmologyst in the past? (Check all that apply.)

  NO

  Yes (Cataract LASIK ICL Cosmetic Retinal desease etc:　　) Age (　　)
- Are you currently on any treatment or medication, including vitamin and nutritional supplement? (Check all that apply.)

  High blood pressure, Diabetes, Heart disease, Stroke, Kidney disease, Cholesterol, Enlarged prostate,

  Other diseases or medications ：
- Do you have any drug allergies? Yes (drugs　　) No
- Did you drive (car, motorcycle, bicycle) today? Yes NO
- Do you use glasses? Yes NO
- Do you use contact lenses? Yes NO
- Do you wear contact lenses today? Yes NO
- Does anyone in your family have an eye disease or surgery? Yes NO

  Yes (　　who :　　) NO
- Have you been vaccinated against Covid-19? Yes (　times) NO
- For women, are you currently or potentially pregnant? Yes NO