NAME _____

●What seems to be the problem?

☐red ☐lid swelling ☐discharge ☐tearing ☐itching
☐gritty ☐eye pain ☐headache ☐loss of vision ☐injury
☐others

_____

●Which eye? ☐right ☐left ☐both

●Since when have you had this problem? _____

●Have you had this same problem before?

☐NO
☐YES When? _____

●Have you had any eye problem before?

☐NO
☐YES How? _____

●Have you had any serious illness?

☐NO
☐YES How? _____

●Have you been allergic to something?

☐NO
☐YES How? _____

●Do you put on glasses or contact lenses daily?

☐For farsightedness ☐For astigmatic
☐For shortsightedness ☐contact lenses (Hard or Soft)

●Do you have high blood pressure?

☐NO ☐YES

●Do you have diabetes?

☐NO ☐YES

●Do you have heart trouble?

☐NO ☐YES