

Office Visit Form

Last Name _____ First Name _____ Age _____ Gender _____ Date _____

Please answer following questions best as you can.

What is the reason you are here? _____

When did the problem start? _____

Which eye has the problem? R L Both

What time of day does the problem start or get worse? _____

What have you done to your eye so far? _____

How has the problem progressed? Same Worse Improving

Have you had the same problem before? Y N

Did you have excessive sun exposure? Y N

Do you have a cold or respiratory infection? Y N

Please mark if you have any of the following since the onset of the problem.

Eye pain Soreness Discharge Increased light sensitivity

Itchiness Redness Excessive tearing Gritty sensation

Burning Stinging Matting of eyelids Vision change

Driness Visual disturbance Flashes Floater

Do you wear contact lens? Y N If Yes, please answer following questions.

What type of contact lens do you wear? Soft Hard

Do you sleep with contacts on? Y N Occasionally