医療法人 畑 眼 科

1 Basic Information

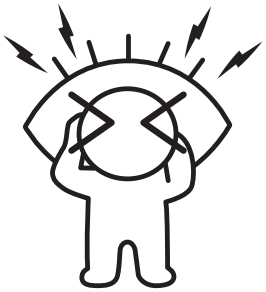
Full Name	Date of Birth
	Gender M F
Address 〒	
Phone Number	
National Health Insurance: ☐ Yes / ☐ No	

2 Main Concern / Reason for Visit

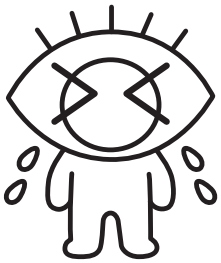
Which eye? ☐ Right Eye ☐ Left Eye ☐ Both Eyes

What are your symptoms?

☐ Pain

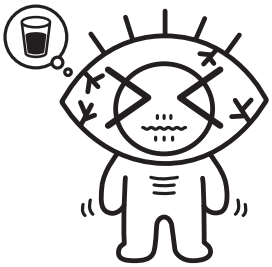


☐ Tearing (watery eyes)



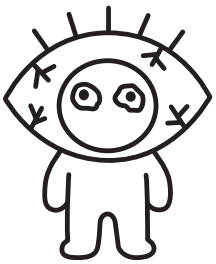
☐ Itchy eyes

☐ Dry eyes

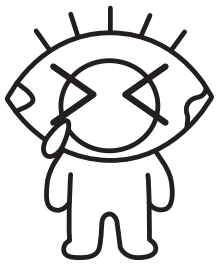


☐ Sensitivity to light

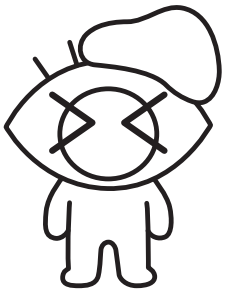
☐ Red eyes



☐ Eye discharge



☐ Lump / Stye



How do you see?

☐ Blurred vision

☐ Partial loss of vision

☐ My vision is double

☐ Floaters (like small insects or dust)

☐ Distorted vision

☐ Other (please describe)

: _____

3 When did the symptoms start?

☐ Today ☐ About 1 week ago ☐ About 1 month ago ☐ Other:

4 Past Eye Conditions

☐ Cataracts ☐ Glaucoma ☐ Retinal bleeding ☐ Allergic conjunctivitis

☐ Other:

5 Current Eye Treatment

Are you using any eye drops from another clinic?		☐ Yes	☐ No
	Do you usually use eye drops?	☐ Yes	☐ No
	Did you bring your eye drops today?	☐ Yes	☐ No

6 Do you use vision correction?

☐ Glasses ☐ Contacts (☐ Soft / ☐ Hard) ☐ None

7 Past medical history

☐ High blood pressure ☐ Diabetes ☐ Other:

8 Allergy History

☐ Drug allergy	☐ House dust Dust mites	☐ Dog Cat allergy	☐ Japanese cedar pollen	☐ Other pollen allergies	☐ Other:
					_____ _____ _____

9 Are you currently pregnant or breastfeeding? (for women only)

☐ Pregnant ☐ Breastfeeding ☐ Neither

10 Please write if you have any other concerns