OPHTHALMOLOGY

Kawasaki Eye Clinic

Check☑ all corresponding answers.

English

Name		☐Male ☐Female	
		Phone	
Date of birth	_____year _____month _____day		
Address			
Nationality		Do you have health insurance?	☐Yes ☐No

What are your symptoms?

☐right eye ☐left eye ☐both eyes

☐tearing ☐pain ☐mucous discharge ☐itching ☐swelling

☐something stuck in the eye ☐blurred vision ☐double vision

☐sensitivity to light ☐others ( )

Do you have any food or medication allergies? ☐No

☐Yes→ ☐medication ( ) ☐food ( ) ☐others

Are you currently taking medication?

☐Yes ( ) ☐No

What illnesses have you had in the past?

☐high blood pressure ☐heart disease ☐diabetes ☐asthma

☐others ( )

Are you currently under medical treatment? ☐Yes ☐No

Does anyone in your family have eye diseases?

☐Yes Who?( ) What?( )

Are you pregnant or there a possibility of pregnancy? ☐Yes ☐No