≪Medical Questionnaire Sheet≫

kana		Date of Birth	year month day
Name	☐ Male ☐ Female		
		Age	years old
Address	〒	Phone	

1. What is your problem?

(☐ right eye ☐ left eye ☐ both eye)

(How long have you had the problem? Since month day)

☐eyesight deterioration
☐eye mucus
☐redness
☐a lot of tears
☐pain
☐itchiness
☐eye strain
☐floater
☐foreign matter
☐other
( )

2. What illnesses have you had in the past？

☐hypertension ☐diabetes ☐hyperlipidemia ☐arrhythmia ☐angina pectoris ☐heart attack
☐atopic dermatitis ☐asthma ☐hay fever ☐rheumatism ☐other（ ）

3. Have you ever had any problems after taking medicine？

☐ No ☐ Yes →( )

4. Do you wear contact lenses?

☐ No ☐ Yes
→ ☐ 1day ☐ 2weeks ☐ other soft contact lens ☐ hard contact lens

5. Are you pregnant?

☐ No ☐ Yes →(months)

Are you currently breastfeeding?

☐ No ☐ Yes →(times a day)

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