SYMPTOMS CHECKLIST

Print Name (Last) ______________________ (First) ________________ Date _________

Address ____ Age _________

____ Sex M / F

Day Phone (________)____________________ Occupation ______________________

What brings you to our office?____

CHECK THE SYMPTOMS YOU EXPERIENCE (√):

	Left Eye	Right Eye	How Long?
Redness	❑	❑	________
Dry Eye Feeling	❑	❑	________
Mucous Discharge	❑	❑	________
Sandy or Gritty Feeling	❑	❑	________
Itching	❑	❑	________
Burning	❑	❑	________
Foreign Body Sensation	❑	❑	________
Constant Tearing	❑	❑	________
Occasional Tearing	❑	❑	________
Watery Eyes	❑	❑	________
Light Sensitivity	❑	❑	________
Eye Pain or Soreness	❑	❑	________
Chronic Infection of Eye or Lids	❑	❑	________
Sties, Chalazion	❑	❑	________
Fluctuating Visual Acuity	❑	❑	________
"Tired" Eyes	❑	❑	________
Contact Lens Discomfort	❑	❑	________
Contact Lens Solution Sensitivity	❑	❑	________

Sinus Congestion	❑
Congestion	❑
Post-Nasal Drip	❑
Cough-Chronic	❑
Bronchitis-Chronic	❑
Allergy Symptoms	❑
Seasonal Allergies	❑
Hay Fever Symptoms	❑
Cold Symptoms	❑
Middle Ear Congestion	❑
Sneezing	❑
Dry Throat, Mouth	❑
Headaches	❑
Asthma Symptoms	❑
Arthritis	❑
Joint Pain	❑

Any Additional Comments: ____

	Yes		
Do you use lubricating eye drops?	❑	What name brand?	________________
Do you wear contact lenses?	❑	How long have you had them?	________________
Are they comfortable?	❑	Have you tried to wear them before and quit?	Yes / No
Do you wear glasses?	❑	How long have you had them?	________________
Have you ever had an eye injury?	❑	Please describe:	________________
Have you ever had eye surgery?	❑	Please describe:	________________
Are you allergic to anything?	❑	Please list:	________________
Do you take any medications?	❑	List name and reason:	________________

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Are your eyes sensitive to (circle): heaters, blowers, air conditioning, cigarette smoke, smog, dust, pollen, pressurized airplane cabins, video display terminals, sunshine, wind, contact lens wear

Have you or a blood relative ever had (circle): glaucoma, tuberculosis, lupus, gout, cataracts, arthritis, diabetes, rheumatoid, thyroid disorder, heart disease, high blood pressure, Sjogren's syndrome

Patient's Signature: ______________________ Dr.'s Signature: ______________________

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