

SYMPTOMS CHECKLIST

Print Name _____

(Last) _____

(First) _____

Date _____

Check Eye Symptoms

You Experience (✓):

	Left	Right
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eye Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation.....	<input type="checkbox"/>	<input type="checkbox"/>
Constant Tearing	<input type="checkbox"/>	<input type="checkbox"/>
Occasional Tearing.....	<input type="checkbox"/>	<input type="checkbox"/>
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lids.....	<input type="checkbox"/>	<input type="checkbox"/>
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>
“Tired” Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens Discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens Solution Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>

Check Any of the Following Symptoms

That You are Having (✓):

Sinus Congestion	<input type="checkbox"/>
Congestion	<input type="checkbox"/>
Post-Nasal Drip.....	<input type="checkbox"/>
Cough-Chronic.....	<input type="checkbox"/>
Bronchitis-Chronic.....	<input type="checkbox"/>
Allergy Symptoms	<input type="checkbox"/>
Seasonal Allergies.....	<input type="checkbox"/>
Hay Fever Symptoms	<input type="checkbox"/>
Cold Symptoms.....	<input type="checkbox"/>
Middle Ear Congestion.....	<input type="checkbox"/>
Sneezing.....	<input type="checkbox"/>
Dry Throat, Mouth.....	<input type="checkbox"/>
Headaches	<input type="checkbox"/>
Asthma Symptoms.....	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>
Joint Pain.....	<input type="checkbox"/>

Any Additional Comments: _____

Yes

Do you use lubricating eye drops?	<input type="checkbox"/>	What brand? _____
Do you wear contact lenses?	<input type="checkbox"/>	How long have you had them? _____
Are they comfortable?	<input type="checkbox"/>	Have you tried contacts before and quit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses?	<input type="checkbox"/>	How long have you had them? _____
Have you ever had an eye injury?	<input type="checkbox"/>	Describe: _____
Have you ever had eye surgery?.....	<input type="checkbox"/>	Describe: _____
Are you allergic to anything?	<input type="checkbox"/>	List: _____
Do you take any medications?.....	<input type="checkbox"/>	List: _____

Are your eyes sensitive to (*circle*):

heaters blowers air conditioning cigarette smoke smog dust pollen
 airplane cabins computer screen sunshine wind contact lens wear

Have you ever had (*circle*):

glaucoma tuberculosis lupus gout cataracts arthritis diabetes rheumatoid
 thyroid disorder heart disease high blood pressure Sjogren's syndrome

Patient's Signature

Date

Dr's. Signature

Date