Medical Office Visit Questionnaire

Patient Name _____ Date _____

1. Which eye is involved? Right Left Both
2. When did this condition develop? (onset) _____
3. Are you a contact lens wearer? Yes No
   - If so, are the lenses still being worn? Yes No
   - If lens wear has been discontinued, when was the last time the lenses were worn? _____
4. Is there a discharge present? Yes No
   - If so, how would you describe the discharge? Watery | Purulent | Stringy | Crustiness Eyelids are glued shut in the morning? | Other _____
5. Do you have any of the following symptoms?
   - Pain | Unusual Light Sensitivity | Blurred vision | Diffused redness | Localized Redness Itching | Burning | Flashes of light | Floaters
6. Have you had any recent colds or illnesses? Yes No
7. What medications, if any, have you already used for this condition? _____
8. Has there been any recent injury to the eye or exposure to other people with eye infections, which may have caused the red eye? _____
9. Are you allergic to any medications? Sulfa | Penicillin | Other _____
10. Are you taking any medications for any other conditions such as diabetes? _____
11. Is there any possibility of pregnancy? Yes No

I realize that I will be responsible for any fees that my private insurance does not cover. There is a fee for the initial visit and for each subsequent visit. If your insurance has a co-pay, it will be due at each visit.

Signature _____