Questionnaire

Name: First _____ Middle _____ Last _____

Nationality:_____ □ Male □ Female

Birthday: year /month /day

Address:_____

May we send you direct mail that has our clinic's name on it? Yes ・ No

Phone (Home):_____ (Mobile):_____

Phone (Emergency):_____

May we use our clinic's name when contacting you by telephone? Yes ・ No

E-mail:_____

1. How did you find our clinic?

□ Magazines ( )

□Newspapers ( )

□ Radio or television ( )

□ Website of Minamiaoyama Eye Clinic

□ Online search (Yahoo, Google, others)

□ Introduced by a friend

□ Referred by an eye clinic or a hospital (Name:)

□ Others ( )

2. Do you usually use contact lenses? Yes・No

What type do you wear?

1 Hard 2 Soft for astigmatism 3 Multifocal

4 Soft regular / disposable (1DAY ・ 1WEEK ・ 2WEEK ・ 1MONTH)

3. Please write your eye symptom(s).

_____

_____

4. □allergy(medication・food)・seasonal( )

5. Please inform us of your medical history, including past surgeries or major illnesses.

☐ Pink eye (conjunctivitis) □ Herpes cornea

☐ Diabetes mellitus (DM) □ Hypertension □ Hepatitis

☐ Others:

6. Are you taking any medications?

Eye drops:

Medicine:

Injections: