

## SYMPTOMS CHECKLIST

Patient Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE NOTE: To ensure a proper Eye Health Examination indicate symptoms or conditions you now experience, or have experienced during the last 12 months. Provide complete answers.**

<u>EYE SYMPTOMS</u>	<u>Right Eye</u>	<u>Left Eye</u>	<u>SECONDARY SYMPTOMS</u>	<u>YES</u>
	YES	YES		YES
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>
Dry Eye Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Congestion	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Head Congestion	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal Drip	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Allergy Symptoms	<input type="checkbox"/>
Constant Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>
Occasional Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cold Symptoms	<input type="checkbox"/>
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Middle Ear Congestion	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth or Throat	<input type="checkbox"/>
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Fluctuating Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	Asthma Symptoms	<input type="checkbox"/>
"Tired" Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or Indigestion	<input type="checkbox"/>
Contact Lens Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>
Contact Lens Solution Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>

**Circle items which you are sensitive to:**

- |                   |                  |
|-------------------|------------------|
| Heaters           | Dust             |
| Blowers           | Pollen           |
| Air Conditioning  | Airplane Cabins  |
| Cigarette Smoke   | Computer Screens |
| Smog              | Sunshine         |
| Contact Lens Wear | Wind             |

**Circle conditions you or a family member (blood relative) have experienced:**

- |              |                     |
|--------------|---------------------|
| Glaucoma     | Diabetes            |
| Tuberculosis | Rheumatoid          |
| Lupus        | Thyroid Disorder    |
| Gout         | Heart Disease       |
| Cataracts    | High Blood Pressure |
| Arthritis    | Sjogren's Syndrome  |

- |                                          |                          |                                    |
|------------------------------------------|--------------------------|------------------------------------|
|                                          | <b>YES</b>               |                                    |
| Do you use lubricating drops?            | <input type="checkbox"/> | What brand? _____                  |
| Do you wear contact lenses               | <input type="checkbox"/> | How often? _____                   |
| Are your contacts comfortable?           | <input type="checkbox"/> | How long have you worn them? _____ |
| Have you tried contacts before and quit? | <input type="checkbox"/> | Why? _____                         |
| Do you use glasses?                      | <input type="checkbox"/> | How long have you had them? _____  |
| Have you ever had an eye injury?         | <input type="checkbox"/> | Describe the injury: _____         |
| Are you allergic to anything?            | <input type="checkbox"/> | List: _____                        |
| Do you take any medications?             | <input type="checkbox"/> | List: _____                        |

Additional comments: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Doctor's Name