TEXAS STATE OPTICAL

Office Visit

Name: _____ Date:_____

Symptoms:

First Noticed: Date:_____ Time:_____ am/pm

Right Eye Left Eye Both Eyes (please circle one)

Please check all that apply:

_____ Red

_____ Swollen

_____ Pain 1 to 10 (1being least 10 being most)

_____ Light Sensitive

_____ Watery

_____ Lashes Sticky

_____ Itchy

_____ Decreased Vision

_____ Discharge crusty mucous stringy (circle one)

_____ Other (describe) _____

1. Are you a contact lens wearer? Yes No **(if no, skip to question 6)**
2. What type of lenses do you wear? Soft Hard Disposable Reusable
3. How long have you had your lenses? _____
4. Do you sleep in your lenses? Yes No If yes, how long do you wear them before removing?_____
5. What solution do you use? Optifree Complete Renu Aquify Boston Original Boston Advance Other (please specify)_____
6. Have you suffered any Eye Injury? Yes No If yes, please describe:_____

_____

7. Are you using any medication presently for your eyes? Yes No If yes please list :_____
8. Are there any additional comments you feel will assist the doctor in treating your condition? _____

_____

9. Are you pregnant, breast feeding, or trying to become pregnant?

_____

Patient Signature:_____ Date: _____