Medical Questionnaire Sheets

No.____________________________

○Please fill the blank

□Male　　□Female

Name_____________________________　　Date of birth（DD/MM/YY）____________________

If you live in Japan, Please fill out the form below.

Address 〒

____

Phone______________________　　Nationality_____________________________

If you are traveling,

Please tell us which hotel you are staying at. ______________________________________

■What is wrong with you, today?　（目の症状について）

□right eye　　□left eye　　□both eyes

＊How long have you had the problem?

Since_________________________________　ago

□itching（痒み）　□discharge　（目やに）　□aching（痛み）

□redness（充血）　□dry eye　（乾燥）　□eyestrain（目の疲れ）

□foreign body sensation/sandy　（異物感）　□blight sparks　（光視）

□blurred vision（ぼやけ）

□You see something flying like mosquitoes before your eyes（飛蚊の症状）

□Your field of vision is getting narrower（視野の狭まり）

□others(____)

■Have you ever been allergic to medication?（薬剤のアレルギー）

□Yes(What kind of medication ?_______________________________________)

■ Do you receive other medical treatments?　(現在治療中の病気があるか)

□No　　□Yes (the name of disease: ____)

＊How long have you had illnesses?　(いつからその病気があるか)

Since________(year)　________(month, date)

＊Do you presently take medication?　(現在投薬治療をしているか)

□No　　□Yes(____)

■Have you ever been through an ophthalmologic surgery? (過去の眼手術の有無)

□No　　□Yes(What kind of surgery?____)

■ Do you wear contact lenses now? (コンタクトレンズ装用の有無)

□No　　□Yes

■ Does anyone in your family have eye disease? (家族の眼疾患の有無)

□No　　□Yes (what kind of disease? ____)

Medical Questionnaire Sheets

Questions for those who want contact lenses:

■**Do you wear contact lenses? (普段コンタクトを付けているか)**

☐ No

☐ Yes

→☐Disposable contact lenses （使い捨て）(1day・2week・1month)

☐Hard contact lenses （HCL）☐Conventional soft contact lenses（コンベ）

■**What kind of contact lenses do you want, today?**（ご希望の CL）

☐Disposable contact lenses (☐1day ☐2weeks ☐1month)

☐Hard contact lenses（HCL） ☐Conventional soft contact lenses（コンベ）

☐Color contact lenses （カラーＣＬ）

■**Have you ever worn contact lenses?**

☐No, this is the first time.

☐Yes （What kind of contact lenses?______________________________________)

＊How long have you used contact lenses? Since________(year) ________(month)

（どのくらい CL 使っているか）

＊What is the brand name of the contact lenses you have used? (__________________)

（使っている CL のブランドの名前）

＊Do you wear contact lenses now? ☐Yes ☐No （今 CL を付けているか）

＊Do you wear glasses? ☐Yes ☐No （めがねを普段使うか）

＊What kind of care products for contact lenses have you ever used? （お使いのケア用品）

(____)

＊Please write down the power of your contact lenses. （右左各度数）

Right eye(________________) Left eye(________________)

■**What is the brand name of the contact lenses that you want?**

(____) ☐I want consultation.()

■**Please answer the following questions.**

☐Do you feel tired when you watch computer screens or play video games for a long time?

☐Do you sometimes find it difficult to put off contact lenses because they stick to your eyes?

☐Would you like to try more comfortable contact lenses?