HATTORI VISION OPTOMETRY

EMERGENCY OFFICE VISIT

Patient's Name: _____ Age: _____

Today's Date: _____ Time: _____ am / pm

Onset of symptoms: _____(Mins/Hrs/Days/Wks)

Have there been any injury to your eyes and/or head? Yes or No

Did you get something in your eyes? _____ (foreign body / chemical)

Have you rinsed your eyes? Yes or No If so, with what? _____

Does this involve your : Right Left or Both Eyes

Do you wear contact lenses? Yes or No

If you do wear contacts are you wearing them now? Yes or No

Are you experiencing any of the following?

____ spots in vision	____ pain	_____ redness
____ veil blocking vision	____ discomfort	_____ discharge
____ part of vision missing	____ burning	_____ swollen lids
____ flashing light in vision	____ scratching	_____ blur
____ itching	____light sensitivity	

Other: _____

Have you experienced this before? Yes or No

If yes, when? _____

Do you have any other illness/condition currently? _____

Are you taking any medications? _____

Are you allergic to any medications? _____

Do you wear contact lenses? Yes or No Are you wearing them now? Yes or No

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