

Name		Date		Time	
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Email		Birth Date	
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Primary contact #		cell	<input type="checkbox"/>	landline	<input type="checkbox"/>
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Please describe your concern:

When did it start?		Any change?	Better	<input type="checkbox"/>	Worse	<input type="checkbox"/>	Same	<input type="checkbox"/>
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Which Eye?	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>	Both	<input type="checkbox"/>	Onset?	Sudden	<input type="checkbox"/>	Gradual	<input type="checkbox"/>
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Have you initiated treatment?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	If yes, what?	
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Contact-lens use?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	If yes, do you wear contacts while asleep?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
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Recent Eye Surgery?	<input type="checkbox"/>		Or Eye Injury?	<input type="checkbox"/>		It's happened before?	<input type="checkbox"/>
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**Check all symptoms that apply:**

Vision Problem?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	If yes, noticed when looking...	Far	<input type="checkbox"/>	Near	<input type="checkbox"/>	Both	<input type="checkbox"/>
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Double vision?	<input type="checkbox"/>	Light sensitivity?	<input type="checkbox"/>	Light <i>flashes</i> ?	<input type="checkbox"/>	New/more <i>spots</i> in vision?	<input type="checkbox"/>
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Eye(s) are red?	<input type="checkbox"/>	Watery eye(s)?	<input type="checkbox"/>	<i>Goupy</i> discharge from eye(s)?	<input type="checkbox"/>	Colour?	
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Something in eye(s)?	<input type="checkbox"/>	Burning?	<input type="checkbox"/>	Itch?	<input type="checkbox"/>	Pain?	<input type="checkbox"/>	New onset headache?	<input type="checkbox"/>
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Please describe the severity of any of the symptoms experienced (a scale 0-10 can be used, zero being no symptom, and ten being the most severe symptom that you could imagine):

Any other relevant info?

<b>Clinic Use Only</b>	Reviewed	<input type="checkbox"/>	D/T	Book: Today	<input type="checkbox"/>	This Week	<input type="checkbox"/>	Tele	<input type="checkbox"/>	ER	<input type="checkbox"/>
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