Stein Optometric

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RED EYE QUESTIONNAIRE

Patient Name:____ Date:________________

1. Which eye is involved?
2. When did this condition first occur? (onset) ____
3. Has this occurred before?
4. Do you wear contact lenses?
    - If so are they still being worn?
    - If so how often do you replace your contact lenses? _______________________________________
    - Do you sleep in your contacts lenses?
    - If you are not wearing your contact lenses right now, when was the last time the lenses were worn?
      ____
5. Is there any discharge present?
    - If so, how would you describe the describe the discharge? Watery, Purulent (thick/white), Ropy (stringy), Crustiness, Eyelids shut in the morning, others?
6. Do you have any of the following symptoms? Pain, unusual light sensitivity, blurred vision, diffused redness, localized redness, itching, or burning?
7. Have you had any recent cold or illnesses?
8. What medications, if any, have you already used for this condition?
9. Do you have allergies? If yes, to what?____
10. Are you allergic to any medications? Other_____________________________
11. Has there been any recent injury to the eye?
    If so where?____
12. Have you been exposed to anyone with an eye infection?
    If so, who/where?____
13. Are you pregnant?