<Outpatient Questionnaire>

To Patients Receiving A Consultation At The Ophthalmology Walk-in Clinic

Name:	Age:	Consultation Ticket No.:
Phone Number (Please provide a phone number we can each as needed.) Tel:		

Please circle the applicable answers to the following questions.

■ Do you have a referral letter from another hospital? ☐ No ☐ Yes

■ Describe your symptoms

_____

_____

_____

_____

■ Have you ever had any serious illnesses?

☐ No ☐ High blood pressure ☐ Diabetes Mellitus

☐ Other (Name of illness: _____)

■ Do you have any allergies (drugs, food, etc.)?

☐ No

☐ Yes (Please specify: _____)

■ Has anyone in your family (including parents) suffered from eye problems?

☐ No

☐ Yes (Please specify: _____)

Thank you for your cooperation.

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