

**For Patients Visiting the Department of Ophthalmology**

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| --- | --- |
| Name : | Age : |
| Email address : | Tel： |

**Please answer to the following questions.**

1. **Do you have a referral letter from another hospital?** NO ・ YES
2. **Describe your symptoms.**
3. **Have you ever had any serious illnesses?**

* No High blood pressure Diabetes Mellitus
* Other (Name of illness: )

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

NO ・ YES (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. **Has anyone in your family (including parents) suffered from eye problems?**

NO ・ YES (Please specify: )

**Thanks for your cooperation!!**