—

_____ Year _____ Month _____ Date of appointment

Please bring this on the day of your appointment !

Eye Questionnaire (Medical History Form)

Address : Otsu-shi

Name (Furigana) : ( )

Date of Birth :

Gestation Period : Week Day • Birth weight g

Please check all applicable boxes for concerns related to your child's eyes.

① ☐ The movement or expression of their eyes seems strange

② ☐ Their eyes are crossed or shift outwards, upwards, or diagonally

③ ☐ They are very sensitive to bright light

④ ☐ They tilt their head or glance their eyes sideways when looking at something

⑤ ☐ They approach things closely to look at them

⑥ ☐ There are times outside when it is bright where they squint one eye to look at something

⑦ ☐ The inside of their pupils looks white-ish

⑧ ☐ The size of their left and right pupils are different

⑨ ☐ Their eyes sway back and forth

⑩ ☐ Their eyelids are drooping

⑪ ☐ They have direct relatives with amblyopia (weak sight), strabismus (crossed eyes), or any other innate eye-related illnesses

⑫ ☐ They are currently visiting an ophthalmologist or undergoing observation for eye related issues

⑬ ☐ Other ( )

These questions reflect symptoms of illnesses that may require treatment.
Please enter any other concerns you may have in the "Other" row

2022/9