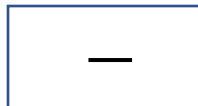


**Please bring this on the day of your appointment !**

\_\_\_\_ Year    \_\_\_\_ Month    \_\_\_\_ Date of 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**

