Patient Symptom Questionnaire

Please check all symptoms you are currently experiencing. This helps us determine whether your visit is routine or medical in nature.

Visual Symptoms

- ☐ Blurry Vision (sudden or gradual)
- ☐ Double Vision
- ☐ Loss of Vision (partial or complete)
- ☐ Flashes of light
- ☐ New or increased floaters
- ☐ Difficulty seeing at night
- ☐ Trouble focusing

Eye Discomfort

- ☐ Eye pain or pressure
- ☐ Headaches around the eyes
- ☐ Eye strain or fatigue
- ☐ Foreign body sensation (feeling like something is in the eye)

Surface/Ocular Health Symptoms

- ☐ Dryness or burning
- ☐ Itching
- ☐ Excessive tearing/watering
- ☐ Redness
- ☐ Light sensitivity
- ☐ Discharge or crusting

Other Concerns

- ☐ Injury or trauma to the eye
- ☐ History of eye surgery
- ☐ Diabetes
- ☐ Hypertension
- ☐ Other systemic conditions
- ☐ Glaucoma
- ☐ Current use of eye medications (drops or ointments)
- ☐ Cataract

Insurance & Billing Notice:

Some symptoms may indicate medical conditions that require billing to your medical insurance instead of your routine vision plan. If today's visit is determined by the doctor to be medical in nature, your medical insurance will be billed. You will be responsible for any copayments, deductibles, or non-covered services in accordance with your insurance policy.

By signing below, you acknowledge that you have read and understand this policy.

Patient Signature:_____

Date:_____