Please fill out this form.

| | FIRST NAME | FAMILY NAME | | <Date of Birth> Year Month Date / / |
|---|---|---|---|---|
| NAME | | | M F | |
| Zip Code | 〒 | | | Home Phone ( - - ) Mobile Pone ( - - ) |
| Address | | | | |
| Occupation | | | | Do you take medicine? No ・ Yes ( ) |

Please Circle.

(1) What is your problem？ (Right・Left・Both EYE)
Bloodshot・Itching・Pain・Swelling・etc
Need prescription for Contact Lenses or Eye glasses
Other ( )

(2) From when did your problem start？
( )

(3) Did you suffer from the eye disease before？
No
Yes →Diagnosis ( )

(4) Do you have following disease？
High Blood Pressure・Diabetes・Chorestelolemia
Cardiac disease・Renal disease・Liver dicease
Allergy (Specify the Antigen )
Other ( )

(5)Did you have any problem with certain drug or injection?
No
Yes →What kind of drug? ( )
What happened？ ( )

(6) To Ladies Only:Are you pregnant? Yes, No
Are you giving the breast? Yes, No

Thank you very much for your cooperation.