Ocular Emergency Interview Form

Patient Name:	**Date:**
Chief complaint:	
Which eye?	
Do you wear contact lenses? • Are they in now? • What kind are they?	
When did it start/ happen?	
Is it getting better, worse, or staying the same?	
Are you in pain? • Where is the pain located? • Describe how it feels • Does it feel like something is in your eye?	

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How is your vision? • Normal? • If abnormal, please describe
Do you have any sensitivity to light?
Is your eye red? Where is the redness?
Do you have any discharge from your eye?
What, if anything, have you done to treat the eye?

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