**Patient Telephone Screening Form**

Name of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient of Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New patient: Yes/No

Time of call \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of call \_\_\_\_\_\_\_\_ New referral from Dr.\_\_\_\_\_\_

Name and title of staff member taking call \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* What is your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When did your problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How suddenly did it begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has the problem worsened, improved, or remained unchanged?
* Does it affect one eye or both? If one eye, which one? Right/Left
* Have you recently had surgery or a procedure? Yes/No
	+ Type and date of surgery/procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has your vision changed? Yes/No
	+ Loss of vision? Yes/No Constant/Intermittent
		- If yes, describe loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Flashes? Yes/No Floaters? Yes/No Shadows in peripheral vision? Yes/No
	+ Change in vision? Yes/No. (circle one and choose type)
		- Double vision? Distorted vision? Fading vision? Other:\_\_\_\_\_\_\_
* Eye pain? Yes/No Location, description, intensity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Has the pain worsened, improved, or remained unchanged?
	+ Did nausea and vomiting accompany the pain? Yes/No
	+ Is there any other type of pain? Yes/No
		- Headache Facial pain Jaw pain or ache Other: \_\_\_\_\_\_\_\_\_\_\_\_
* Are your eyes red? Yes/No
	+ Has redness worsened, improved, or remained unchanged?
* Discharge from the eye? Yes/No. If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Eyelids stick together? Yes/No.
* Any burn/injury to the eye, forehead, or face? Yes/No
	+ Eyelid damaged? Yes/No Pain? Yes/No Vision loss? Yes/No
	+ Describe how burn/injury occurred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you wear contact lens? Yes/No Glasses? Yes/No
* Any other problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of appointment: Emergent Urgent Routine

Date and time of appointment:

Ophthalmologist’s advice or instruction: