Appointment Request

* required field

- Patient Name *

  ______________________ Age: ______ Sex: M F

- New Patient? Yes / No
- Home Address

  ____

- E-mail Address*

  ____

- Phone Number

  ________ - __________ - __________

- Preferred Day of Appointment* (Please encircle)

  Mon, Tue, Wed, Thu, Fri, Sat

  Preferred Hour of Consultation*

  ______~______a.m. ______~______p.m.

- What is the problem with your eyes? (Please encircle)

  (Right, Left, or Both eyes)

  Visual disturbance, Difficulty in reading, Pain, Itchiness,

  Wish for glasses or contact lenses,

  Floaters, Redness, Watery, Swelling, Eye check-up

  Others: ________________________

- Are you taking any prescription medications?

  ____

- Have you ever had allergic reactions for medications or allergy? (If yes, please indicate)

  ____

- Do you have hypertension, diabetic mellius, or heart problems?

  ____

- Where did you hear about our clinic?

  ____

- How did you find our website?

  ____

- Other Comments or Requests *

Please fill out the request form above and send us a fax at (078) 923-0050 or email (fujiieyecenter@opal.plala.or.jp) (English only).