



B. Athwal, MD H. Athwal, MD
L. Althwal, MD
14 Mule Road, Suite 1
Toms River, NJ 08753
Phone: 732-286-0900

Patient Questionnaire

Patient Name: _____ Account #: _____

Please circle the answers to the following questions:

- | | | |
|---|-----|----|
| 1. Are you a smoker? | Yes | No |
| 2. Did you have the Flu shot this year? | Yes | No |
| 3. Had the Pneumonia shot within the past 5 years? | Yes | No |
| 4. Do dry eyes interfere with your leisure/work activities? | Yes | No |
| 5. Would you like to discuss treatments for dry eyes? | Yes | No |

6. Have you experienced any of the following symptoms?
Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Painful or sore eyes | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Tired eyes | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Eyes that feel gritty | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Frequent blinking | <input type="checkbox"/> Fans or vents increase irritation |