

WELCOME TO OUR OFFICE

Please answer the following questions to help us give you a comprehensive eye examination and a treatment plan that meets your particular needs. Thank you for your cooperation.

Name: Occupation:

What was the approximate date of your last eye exam:

Who was the eye doctor?

What is the main reason for today's eye examination?

Do you have any long standing medical problems? Yes No

If yes, please specify:

Are you on any medications or vitamin supplements presently? Yes No

If yes , please specify:

Have you ever had an eye injury, disease or operation? Yes No

If yes, please describe:

Have you ever worn contact lenses? Yes No

If yes, what type of lenses?

Are you currently wearing contact lenses? Yes No

Are you interested in learning more about contact lenses? Yes No

Are you overly sensitive to sunlight? Yes No

Are you bothered by night driving, glare or surface reflections? Yes No

Do you participate in any of the following sports?

Golf Tennis Racquet Ball Basketball Skiing Boating

Hockey Swimming Biking Other

Do you have any of the following hobbies?

Needlework/Sewing Woodworking/Shop work Stamp Collecting

Computer/hours per day

Music Reading Other

How did you first hear about our office?

Referred by a friend. Please name:

Yellow pages

Office Sign

Welcome Wagon

Other / Doctor

Do you have any preschool/school age children, and if so when was their last eye

examination?

Do you have any old spectacles that you could donate to an overseas vision project? Yes No