Welcome back to our office. In order to provide us with a better understanding of your vision care needs, please complete the following. ***-Thank You***

Name: ______________________ Today's Date: ____/____/________

Birth Date: ____/____/________

Age: ______________________

Do you have any specific problems or questions you would like to discuss with your doctor?

- ❑ No, I'm here for my routine annual exam.
- ❑ Yes. Please list any problems or specific questions for your doctor.
  1. ______________________
  2. ______________________

Since your last visit have there been any changes in your name, address or phone number?

- ❑ No
- ❑ Yes, please indicate changes:

Name ______________________

Address ______________________

City ______________ State ________ Zip ______________

Telephone (H) ______________ (W) ______________

Email: ______________________

Are you interested in learning more about LASIK or laser vision correction?	❑ Y	❑ N
Are you experiencing any difficulty with dry eyes?	❑ Y	❑ N
Do you wear prescription sunglasses for driving or outdoor activities?	❑ Y	❑ N
Do you use a computer at work or home?	❑ Y	❑ N

If yes, approximately how many hours per day?

- ❑ 0-2
- ❑ 2-4
- ❑ 4-6
- ❑ More than 6

Since your last visit have there been any changes in:

1. Your medical history or medications?	❑ Y	❑ N
If yes, please indicate: ______________________		
2. Your eye health history?	❑ Y	❑ N
If yes, please indicate: ______________________		
Are you pregnant or nursing?	❑ Y	❑ N

______________________ ______________

Doctor's Signature Date