



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 (Home) _____ (Work) _____
Email _____

Are you interested in learning more about LASIK or laser vision correction? Yes No

Are you experiencing any difficulty with dry eyes? Yes No

Do you wear prescription sunglasses for driving or outdoor activities? Yes No

Do you use a computer at work or home? Yes No

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:

- Your medical history or medications? Yes No
If "yes," please indicate: _____
Your eye health history? Yes No
If "yes," please indicate: _____

Are you pregnant or nursing? Yes No

I acknowledge that I have been made aware of the HIPPA Notice of Privacy Practices.

Patient Name _____ Signature _____ Date _____

Doctor's Signature _____ Date _____