Virginia Vision Associates

RETURNING PATIENT INFORMATION

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:

1. Your medical history or medications? ☐ Yes ☐ No
   If "yes," please indicate: _____
2. 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 _____