WELCOME BACK TO OUR OFFICE

Date _____

Changes: in personal information

in medications or health history

in experiences

Problems with present glasses or contacts?

Diagnostic Issues

Please list any complaints about wearing glasses or contacts?

* Do you have more than 1 pair Of current Rx glasses? NO YES

*Do you work on a computer for long periods? NO YES

*Do you spend a lot of time outdoors? NO YES

* If you wear glasses, would you benefit from thinner, lighter lenses? NO YES

* If you wear bifocals, are you bother by by restricted windows, lines or head tilting? NO YES

* If you wear contact lenses, are you satisfied with vision and comfort? NO YES

* Are you interested in a test drive of the latest in contact lens design? NO YES

* Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts Do you desire information regarding laser vision correction and/or free evaluation regarding your candidacy? NO YES

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