

"Vision Care From Our Family To Yours"



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Welcome Back to Our Office

Please review the information on the reverse side to determine if there have been any changes to information since your last visit.

Date _____

Changes: _____
Occupation _____
Leisure time activities _____

In medications or health history

Major purpose of visit: _____

Diagnostic Issues

Please list any complaints about wearing glasses or Contacts

Date _____

Changes: _____
Occupation _____
Leisure time activities _____

In medications or health history

Major purpose of visit: _____

Diagnostic Issues

Please list any complaints about wearing glasses or Contacts

- Do you have more than one pair of current glasses? Yes No
- Do you work on a computer for long periods? Yes No
- If you wear glasses, would you benefit from thinner, lighter lenses? Yes No
- Do you spend a lot of time outdoors? Yes No
- If you wear bifocals, are you bothered by restricted windows, lines or head tilting? Yes No
- Are there times you'd rather not wear glasses? Yes No
- If you wear contact lenses, are you satisfied with vision and comfort? Yes No
- Are you interested in a "test drive" of the latest in contact lens design(s)? Yes No
- Would you like information regarding laser vision correction or a free evaluation of your suitability? Yes No

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