VISION SOURCE
INSIGHT EYECARE

For a Lifetime of Healthy Eyesight

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Welcome Back to Our Office

Patients Name_________________________ **Date**_________________________

Changes in Personal Information:

____
____
____

Changes in medications or health history:

____
____
____

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? ☐ No ☐ Yes

If yes, how many hours a day? __________

If you wear glasses, would you benefit from thinner lighter glasses? ☐ No ☐ Yes

Do you spend a lot of time outdoors? ☐ No ☐ Yes
If so, how many hours per week? _________

If you wear bifocals, are you bothered by restricted windows, lines, or head tilting? ☐ No ☐ Yes

Are there times you'd rather not wear glasses? ☐ 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 correction and/or a free evaluation regarding your candidacy? ☐ No ☐ Yes

Do you wear contact lenses? ☐ Yes ☐ No

Are you interested in a "test drive" of the latest in contact lens designs? ☐ Yes ☐ No

Do You Experience...

Any discomfort with your eyes? ☐ Yes ☐ No

Any problems with glare or reflection? ☐ Yes ☐ No

Sensitivity to Sunlight? ☐ Yes ☐ No

Headaches? ☐ Yes ☐ No

Tired eyes when reading? ☐ Yes ☐ No

Floaters or flashes of light? ☐ Yes ☐ No