

WELCOME BACK TO OUR OFFICE

Last Name: _____ First Name: _____ Age: _____

Date: _____ Appt with: Dr. Smith _____ Dr. Graham _____ Dr. Israelson _____

MAIN REASON(S) FOR TODAY'S VISIT: (please check all that apply)

Routine Vision Exam _____ Update Glasses _____ Update Contact Lenses _____

LASIK Consult _____ Contact Lens Fitting _____ Eye Health Exam _____ Other _____

Are you experiencing any of the following?: (please check all that apply)

Blurred distance vision _____ Blurred near vision _____ Both _____ Poor night vision _____

Floaters _____ Flashes of Light _____ Headaches _____ Dry eyes _____ Computer eyestrain _____

Please Review Your Medical & Eye History Form and sign below:

I have reviewed the attached Medical & Eye History Form. I have noted any changes to my general and eye health status and medications. _____ **OR** No Change _____

Signature: _____ Date: _____

Please let our staff know if you have any changes to your address, phone numbers, or insurance information since your last visit with us.

STAFF USE ONLY BELOW THIS LINE

Vision Ins: _____ Medical Ins: _____

Address/Phone change?: _____

O: _____ Tech: _____

