PATIENT INFORMATION QUESTIONAIRE

DEAR PATIENT:

So that we may better meet your vision care needs, please complete the questions below regarding your visit to our office and your participation in hobbies, sports, and computer usage.

1. Your reason(s) for visiting our office today: (Please check appropriate items)

__General check-up	__Blurred distance vision	__Eyes water
__Lost or broken eyeglasses	__Blurred near vision	__Eyes itch
__Want new eyeglasses	__Eyes feel tired	__Eyes feel dry
__Want contact lenses	__Double vision	__Pain in eyes
__Soft disposable	__Headaches	__Night vision
__Light sensitive	__Golf glasses	__Interested in lasik
__Bifocal contact lenses	__Other (please list)	_____
__Gas permeable	_____	_____

2. Please circle those activities in which you participate .

Golf	basketball	skiing	football	baseball/ softball
tennis/ racquetball	Soccer	swimming	hunting	fishing
bowling	volleyball	Biking	TV	walking/ Jogging
rollerblade	dancing	aerobics	reading	gardening
crafts	musical instrument	Scuba	sewing	woodwork
boating				

3. How many hours a day do you use a computer? _____

Thank you