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)						
2	General check-upLost or broken eyeglassesWant new eyeglassesWant contact lensesSoft disposableLight sensitiveBifocal contact lensesGas permeable			Blu Eye Dou Hea Gol Oth	rred distance virred near vision es feel tired able vision adaches f glasses er (please list)		Eyes water Eyes itch Eyes feel dry Pain in eyes Night vision Interested in lasik
2.	Please circle those activities in which you participate.						
	Golf	basketball	skiing		football	basebal softball	
	tennis/racquetbal	Soccer 1	swimmi	ing	hunting	fishing	
	-	volleyball	Biking		TV	walking/ Jogging	
	rollerblade dancing		aerobics		reading	gardening	
	crafts	musical instrument	Scuba		sewing	woodw	ork
	boating						
3.	How many hours a day do you use a computer?						
Th	ank you						