

Welcome Back!

Date: _____ Name: _____

Best telephone # to reach you at? _____

Are we able to text you when an order is ready for pick up? Yes No
(If Yes, to what number?) _____

Changes to insurance company and/or plan? _____

Changes in home address? _____

Changes in medication or health? _____

Any problems with present glasses or contacts? _____

Diagnostic Issues

Do you have more than one pair of glasses?	Yes	No	NA
Do you work on a computer for long periods of time?	Yes	No	
Are you protecting your eyes from sunburn and/or glare with sunglasses?	Yes	No	NA
If you wear glasses, would you benefit from thinner and lighter lenses?	Yes	No	
If you wear bifocals, are you bothered by restricted areas, lines or head tilting?	Yes	No	NA
Are you bothered by glare when driving at night?	Yes	No	NA
Are you interested in trying contact lenses?	Yes	No	
If you wear contacts, are you happy with vision and comfort?	Yes	No	NA