PRE-EXAMINATION QUESTIONAIRE

NAME: _____ DATE: _____

1) Have you ever had a complete eye examination? YES NO
   Approximately how long ago? _____

2) Who is your medical doctor: _____

3) List any medications you are currently taking _____

   Do you smoke? YES NO ____Packs/Day
   Do you drink alcohol? Yes NO Frequency_____
   Other Drug Usage_____

4) Are you allergic to any medications? _____

5) Do you wear glasses? YES NO
   Is your prescription for: Distance Near Both

6) Do you wear contact lenses? YES NO
   Is your vision clear and lenses comfortable? YES NO
   What is your wearing time?

7) Are you interested in wearing contact lenses? YES NO

8) Do you experience:
   _____ Difficulty seeing
   _____ Dry eyes
   _____ Flashes or floaters
   _____ Eye fatigue
   _____ Headaches
   _____ Poor night vision

9) Have you ever had eye surgery? YES NO
   If yes what type? _____ Which eye? _____
   Date of Surgery _____

10) Do you want?
   _____ New glasses
   _____ Contact lenses
   _____ Sunglasses
   _____ Safety glasses
   _____ Sport glasses
   _____ Change eye color
   _____ LASIK Surgery