# *WELCOME TO OPTIX*

***So that we may best serve your eyecare needs, please complete the following questionnaire.***

Last Name_____ First Name _____ Date _____
Street Address _____
City _____ State _____ Zip Code _____
"Preferred" tel. #: (home / work / cell) _____Email _____
Marital status: __ married __ single __ partner __ widowed Spouse's name _____
Employer _____ Job/Title/Position _____
Emergency contact _____ phone _____ relationship_____
How did you find us? __ website __ social media __ insurance __ walk by __ referral
Referrals are very important to us. Whom may we thank? _____

***Meaningful Use demographic information***
*Race: (circle) American Indian, Alaska Native, Asian, Black or African American, Hispanic, Hawaiian, other Native Pacific Islander, Caucasian*
*Preferred Language _____ Ethnicity _____*
*Gender __ Male __ Female*

***Please help us serve you better by answering these additional questions.***

- *What are your hobbies? _____ Leisure activities?_____*
- *What job requirements do you have? __ computer work __ outdoor work __safety eyewear __ considerable reading other _____*
- *Please list any activities that may require special vision needs _____*
- *Do you have difficulty with distance vision? Yes/No*
- *Do you have difficulty driving at night? Yes/No*
- *Do you consider yourself sensitive to sunlight? Yes/No*
- *What close work do you have difficulty with? __ reading __ computer __ hobbies*
- *Do you wear glasses? Yes/No*
- *Are you interested in Lasik or CRT? Yes/No*
- *Do you currently wear prescription/non-prescription sunglasses? Yes/No*
- *Regarding current eyewear, are you dissatisfied with: __ vision __ comfort __ look/style __ age*
- *Do you use computers at: Home/work/both Laptop/Desktop/Mobile devices*
- *Are you on the computer more than 4 hours a day? Yes/No*
- *Do you wear contact lenses? Yes/No Brand _____ Type _____*
- *Contact lens Rx: Right_____ Left _____*
- *Do you sleep in your contact lenses? Yes/No*
- *How often do you change your contact lenses? __daily __ weekly __2 weeks __monthly*
- *Contact lens solution _____*
- *DO YOU WANT YOUR CONTACT LENS PRESCRIPTION RENEWED? Yes/No*

***Would you prefer to be contacted by: email / text / phone***

***Reviewed by_____( )No changes Date_____***
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