



Dr. Amir Khoshnevis
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Vision Source!
A Network of Premier Eye Care Practices

Welcome Back to our Office

Patient's Name _____

Today's Date _____

Employer (or school) _____

Occupation (or grade) _____

E-mail Address _____

* Carolina Family Eye Care respects your right to privacy. Your email address is confidential and intended solely for the purpose of contacting you. It will not be shared with any of our vendors or other mailing lists.

Do you participate in a flex spending account? Yes No

How will you settle your account today? Cash Check Credit Card

Since your last eye health evaluation with us, has there been (Please elaborate if "yes")

Any change in your general health? Yes No

Any change in your regular medications? Yes No

Are you pregnant? Yes No Breastfeeding? Yes No

Eye Care for your Lifestyle

Do you..... (Please check the box if "yes")

- Work at the computer
- Think you might benefit from thinner, lighter lenses?
- Have more than one pair of current prescription glasses?
- Spend time outdoors? How much? _____ hours/week.
- Have prescription sunglasses?
- Prefer not to wear your glasses at times?
- Have interest in a Test Drive of the latest contact lens designs?
- Want information on Laser Vision Correction surgery?
- Have interest in a non-surgical approach to vision correction?
- Have children?
- Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you? Yes No

If you wear contact lenses, are you satisfied with the vision and comfort? Yes No

How many nights a week do you sleep in your contact lenses? _____

How often do you replace your contact lenses? _____

Are you interested in changing your eye color? Yes No

Are you interested in purchasing new prescription glasses today? Yes No

Please list your hobbies: _____