

**WELCOME BACK TO OUR OFFICE**



**Vista Eye Care**

*Your vision is our focus*

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation/School Grade \_\_\_\_\_

Hobbies: \_\_\_\_\_

**REASON FOR VISIT (check all that apply):** Exam Glasses Contacts Eye infection/injury  
Medical problem Other \_\_\_\_\_

Are you planning to get new glasses on this visit? Yes No If necessary

Do you have an interest in a %Test Drive+of the latest contact lens design? Yes No

**Do You.....(check box if your answer is yes):**

- Work at a computer?(\_\_\_\_hrs/day)       Have computer or reading glasses?
- Spend time outdoors? (\_\_\_\_hrs/week)       Have prescription sunglasses?

**Do you currently or have you recently experienced any of the following? (check box if yes):**

- Blurred vision       Burning eyes       Floaters       Headaches
- Itching eyes       Watery eyes       Flashes of light       Double vision
- Red eyes       Sandy/gritty feeling       Loss of vision       Eye strain
- Dry eyes       Eye pain       Poor night vision       Light sensitivity

Are there any other questions or concerns you would like to discuss with the doctor today?

\_\_\_\_\_  
\_\_\_\_\_

**~ Ask us about: Transitions, Transitions XTRActive, Nonglare and Polarized lenses! ~**

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For Office Use Only

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

Scanned \_\_\_\_\_