# Annual Exam Questionnaire

Employer: Occupation:

Height: Weight:

PCP (Primary Care Physician):

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Do you use tobacco products? ○ Yes ○ No

If yes, type/amount:

Do you wear glasses? ○ Yes ○ No

If yes, how old is your current pair of lenses?

Do you wear contact lenses? ○ Yes ○ No

If yes, how old is your current pair of lenses?

Type of contact lenses: ○ Rigid ○ Soft ○ Other

Are they comfortable? ○ Yes ○ No

Are you interested in contact lenses or needing to renew your contact lens prescription? (Additional contact lens exam fee will apply). ○ Yes ○ No

Are you interested in LASIK? ○ Yes ○ No

Have you noticed any change in your vision or other issues with your eyes? ○ Yes ○ No ○ Maybe
(i.e. trouble focusing, blurry vision, etc.)

If yes, please explain:

Are there any medications that you are allergic to? ○ Yes ○ No
If yes, explain or **attach list:**

List any medications you take (including prescriptions, oral contraceptives, vitamins, aspirin, over the counter medications, and home remedies) or **attach list:**

List any <u>recent</u> (since your last exam here) changes to your **medical history**: (i.e. hypertension, elevated cholesterol, diabetes, etc.)