



**OPTOMETRY CENTER**  
**1575 B STREET, HAYWARD, CA 94541**  
**(510)581-1430      www.theoptometrycenter.com**

**Please fill out this form prior to your examination, so we may address all your eye care needs. In addition, please bring this form, the completed Medical History Form and your Insurance Card with you on your appointment day.**

**OFFICE QUESTIONNAIRE:**

- 1. Do you suffer from dry or itchy eyes?  
a. Yes      b. No
- 2. How often do you use the computer?  
a. Never    b. Rarely    c. Sometimes    d. Often    e. Always  
Do you experience any eye strain while using the computer?  
b. Yes      b. No
- 3. Do you play any sports?  
a. Yes      b. No  
If so, specify \_\_\_\_\_
- 4. Do you have any concerns about inherited health conditions? (Such as Diabetes, Hypertension, Cholesterol, Cataract, Glaucoma, Macular Degeneration or any others)  
a. Yes      b. No  
If so, specify \_\_\_\_\_

**EYE CARE INTERESTS:**

- 5. Are you interested in trying Contact Lenses?  
a. Yes      b. No  
If so, how often would you wear them?  
b. Never    b. Rarely    c. Sometimes    d. Often    e. Always
- 6. Are you interested in specialty eye wear (such as protective gear for racket ball or diving)?  
a. Yes      b. No
- 7. Have you ever considered or were interested in obtaining information about Lasik Surgery?  
a. Yes      b. No
- 8. List any other concerns/questions you may have:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_