Atlantic Eye, LLC

LIFE STYLE QUESTIONNAIRE

Patient's Last Name:_____ First Name:_____Middle Initial:_____

Date of Birth:_____ Race: _____ Ethnicity: Non Hispanic Hispanic

Gender:_____ Marital Status: S M D W Preferred Language: _____

Primary Care Physician Name: _____Phone:_____

How did you hear about the practice? TV, Newspaper, Radio, Internet, Other?_____

Occupation: _____

Personal Hobbies / Interests: _____

Do you wear: Glasses (Single Vision / Bifocal / Progressive)
Contact Lenses (Daily Wear / Extended Wear / Rigid Gas Permeable) Last used: _____

Are you: Right Handed Left Handed

Date of Last Eye Exam: _____ Facility / Physician: _____

Corrective Lenses – Likes / Dislikes: _____

_____

OFFICE USE ONLY: *****ATTACH AR HERE*****

Lenso { C/L Rx {

DVA sc { DVA cc {

NVA sc { NVA cc {

Pachy {

Notes: _____

_____

_____

_____

Account # _____