ARNOLD M. STOKOL, O.D.
and Associates

WELCOME BACK

All information received is kept strictly confidential.

Last Name: Date:

First Name: M.I. Email Address:

Mr./Mrs./Ms./Dr. Birth Date: Social Security #:

Preferred First Name: Employer:

Address: Occupation:

City: State: Zip: Marital Status

Home Phone: ( ) Spouse's Name:

Work Phone: ( ) Driver's License #

Mobile Phone: ( ) Medicare #

Preferred Contact Number: ☐ Home ☐ Work ☐ Mobile

List any medications you are taking (including hormones, birth control, vitamins, etc.):

List any medications you are allergic to:

Are you interested in Lasik surgery? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

How many hours a day are you on a computer?

Do you have headaches? ☐ Yes ☐ No How often?

Describe your headaches:

Family eye health problems (such as glaucoma):

Contact Lens Wearers

Which type of disinfecting solution do you use?

How many hours a day do you wear your contact lenses?

How many hours have they been in today?

How often do you replace each pair of contact lenses?

Signature Date