

Due to recent changes in healthcare, additional information must be obtained to be compliant with federal requirements. If you feel uncomfortable answering any specific questions, please let your technician know and you may discuss it with your eye doctor.

(Please check one in each category)

**Preferred Language:** English Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:** American Indian or Asian African American Hispanic White Alaska Native

Native Hawaiian or Other \_\_\_\_\_\_\_\_\_\_\_\_

Other Pacific Island

**Ethnicity:** Hispanic/Latino Native Hawaiian/ Not Hispanic/Latino

Other Pacific Island

**Height** (inches):\_\_\_\_\_\_\_\_\_\_\_ **Weight** (pounds):\_\_\_\_\_\_\_\_\_\_\_

**Do you currently smoke tobacco?** Yes No

If yes, how many packs a day? \_\_\_\_\_\_ How many years have you been smoking? \_\_\_\_\_\_

**Communication Preference:** E-mail Text Phone

We appreciate your cooperation with the healthcare changes to provide you and your family with the best care possible.