Do you notice any glare or halos at nighttime? (This may be noticed as a ring or reflection around streetlights, or headlights.) **___Yes ___No**

Is your nighttime vision worse that your daytime vision? **___Yes ___No**

Have you ever been turned down for laser vision correction? **___Yes ___No**

If yes, please list the reasons: _________________________________

Are you an eye rubber? **___Yes ___No**

Are your eyes dry? **___Yes ___No**

Are you taking antidepressant medication? **___Yes ___No**

Are you taking antihistamine medication? **___Yes ___No**

Are you taking steroids? **___Yes ___No**

Do you have an active disease affecting your body? **___Yes ___No**

Please list: ____

(Female Patients) Are you pregnant or nursing? **___Yes ___No**

Who referred you to our practice? __________________________________

Did you learn about Dr. Mandel from the web? **___Yes ___No**

If yes, please circle one of the following:

Google

Yahoo

Top Doctors America

New York Magazine Best Doctors