What Are Your Visual Needs?

To better help your physician diagnose and provide a solution for your vision needs, please fill out the following information:

Name: _____

Cell _____ Is it ok to text? Y N

E-mail:_____ Is it ok to E-mail? Y N

Occupation:

_____

Do you work with power tools? Yes No

Is eye protection a concern for you? Yes No

What is your main working distance?

-Near/16 in. -Inter/30 in. -Far

How much time do you spend each day at a computer/Ipad/tablet?

- ☐ 0-1 hour
- ☐ 1-3 hours
- ☐ 3-5 hours
- ☐ 5+ hours

Do you spend most of your time…

- Indoors -Outdoors

Is being fashionable important to you? Yes No

What do you like about your current glasses? (Color, style, fit, etc.)

_____

What don't you like about your current glasses (weight, thickness, glare, etc.)

_____

Do you have a backup pair of glasses? Yes No

Are you wanting to get new glasses today or a second pair? Yes No

Do you have prescription sunglasses? Yes No

Is cost one of the most important factors when getting glasses or contacts? Yes No

If you currently wear glasses, how old are they? _____

(If your glasses are older than 3 years, we recommend they be updated. Due to prescription changes and wear and tear over time, older glasses may reduce the sharpness of your vision.)

Are you aware of the benefits of anti-reflective/non-glare glasses? Yes No

Anti-reflective lenses (not sunglasses) can help:

- Increase nighttime driving safety by reducing glare from vehicle headlights.
- Reduce fatigue and eye strain from pc screen reflections and overhead office lighting.
- Makes lenses appear virtually invisible.

Would you like information about Lasik surgery? Yes No

For contact lens wearers

Are you interested in contacts that you can sleep in? Yes No

Would you like contacts that don't require cleaning? Yes No

Do your allergies irritate your eyes while wearing contacts? Yes No

Are glasses sometimes more comfortable than your contacts? Yes No

What would you change about your Contact lenses? _____