

Your Eye Care Needs

Date: _____

Name: _____
(Patient's Name)

1. **How many pairs of glasses do you regularly use? _____ Check all that apply:**

- Distance Only Lined bifocals Computer Glasses
 Reading Only Sunglasses Progressive No-line Multifocals

2. **Do you currently have problems with any of the following? Check all that apply:**

- Night Time Glare Bright Sunlight Close-up Vision for Detail Work
 Computer Glare Intermediate Vision for
 Fluorescent Lighting Computer Work

3. **Do you wear prescription sunglasses?** Yes No

Are they polarized? Yes No

4. **Please check activities that apply to you.**

- Snow Skiing Hiking Public Speaking Soccer
 Boating Golfing Office Work Softball/Baseball
 Fishing Tennis Computer Use Football
 Crafts Gardening Music Jogging
 Swimming Biking Archery Other _____

5. **Are you interested in Contact Lenses?** Yes No

6. **Would you like information on surgical alternatives for Vision Correction?** Yes No

7. **Do your eyes ever feel or do you experience any of the following?
Check all that apply:**

- Gritty or sandy sensation Pain or soreness Fluctuating vision
 Occasional Tearing Blurred vision while reading
 Discomfort in windy conditions Discomfort in air conditioned areas
 Dryness Burning