

Name _____

In order to get to you and your visual life better, please check off the following activities that apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Computer | <input type="checkbox"/> Biking | <input type="checkbox"/> Running |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Playing Musical Instrument | <input type="checkbox"/> Playing Cards |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Sewing | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Skateboard/Scooter | <input type="checkbox"/> Bowling |
| <input type="checkbox"/> Fishing | <input type="checkbox"/> Movies | <input type="checkbox"/> Shooting Sports |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Football | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Basketball | <input type="checkbox"/> Racquet Sports |
| <input type="checkbox"/> TV | <input type="checkbox"/> Skiing/Snowboarding | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Hunting | |
| <input type="checkbox"/> Camping/Hiking | <input type="checkbox"/> Water Sports/Sailing/Surfing/Jet | |
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Woodworking/Carpentry | |

Please indicate any eye symptoms you have been experiencing (please check):

- | | |
|---|--|
| <input type="checkbox"/> No symptoms | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eyestrain/Discomfort | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Light Sensitivity |
| <input type="checkbox"/> Halos | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Pain in/around eye | |

Glasses

Do you currently wear glasses? Y/N If yes, how old are your current glasses? _____

Could you function if your glasses were lost or broken? Y/N

Do you have a useable pair of glasses as emergency? Y/N

In general, I feel my current glasses are (please check)...

- | | |
|---|------------------------------------|
| <input type="checkbox"/> in need of updating | <input type="checkbox"/> just fine |
| <input type="checkbox"/> in need of repair | <input type="checkbox"/> n/a |
| <input type="checkbox"/> uncomfortable and/or old style | |

Do you wear sunglasses? Y/N

When doing close work I ...(please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> do not use glasses to read | <input type="checkbox"/> use single vision readers |
| <input type="checkbox"/> like to recline when I read | <input type="checkbox"/> use no line lenses/progressives |
| <input type="checkbox"/> dislike my bifocals | <input type="checkbox"/> use special lenses for computer use/other |

If applicable, I'd like my next glasses to be...(please check)

- | | |
|--|--|
| <input type="checkbox"/> scratch resistant | <input type="checkbox"/> more durable more comfortable |
| <input type="checkbox"/> reflection-free | <input type="checkbox"/> no-line bifocals/progressives |
| <input type="checkbox"/> lighter-weight | <input type="checkbox"/> polarized lenses |
| <input type="checkbox"/> more fashionable | <input type="checkbox"/> able to darken when I go outdoors |

Contacts

Do you currently wear contacts? Y/N (*if NO, please skip this section*)

would like to know if I am a candidate

What percent of your time do you wear contact lenses? _____%

Are your current contact lenses comfortable? Y/N

Do you have “monovision” with contact lenses? Y/N Don’t what monovision is.

I see better with overall with my: contact lenses glasses

Is your vision blurry with contacts? Y/N

If your vision is blurry, at what distance?

Distance

Near

Mid-range

How old are your current contacts?

What brand of contacts do you wear?

How often do you replace your contacts?

Laser Vision Correction (LASIK)

Have you ever been told that you are a good candidate for LASIK or other types of refractive surgery? Y/N

Are you interested in learning whether you are a candidate for laser vision correction? Y/N

Occupational/Computer Vision

What is your occupation? _____

Do you typically spend more than one hour a day at the computer? Y/N

If yes, which applications (check all that apply) do you use?

MS Word (or other word processing applications)

MS Outlook

Web Browser

Adobe Illustrator

(Internet Explorer, Netscape, Firefox)

MS Excel

Adobe Photoshop

AutoCAD

MS PowerPoint

QuickBooks

Please check all that apply:

- I spend a lot of time outdoors
- I have trouble seeing at night
- My job/lifestyle involves both indoor and outdoor activities
- I am uncomfortable with the weight and/or thickness of my glasses
- I am light sensitive, driving in bright sunlight and glare bother me

I have trouble with close work while:

- Reading
- Using the computer
- Partaking in hobbies
- I participate in active or competitive sports
- My current eyewear doesn't meet my performance needs for work and recreation

I consider myself to be:

- Fashion Confused
 - I consider eyewear only as a medical device
 - Comfort and vision are all I care about in eyewear
 - I rarely update my wardrobe or change my look
- Fashion Conservative
 - I prefer classic, traditional styles
 - I am not really influenced by fads or trends
 - I feel eyewear should be minimal or subtle
- Fashion Conscious/Curious
 - I have an updated style
 - I am interested in new trends
 - I consider my eyewear a fashion/accessory item
 - I believe eyewear should reflect my image
- Fashion Cutting edge
 - I am a trend setter and fashion forward
 - I am willing to take risks with my overall look
 - I value and recognize designer brands
 - Accessories are a must for me
 - I believe my eyewear should make a statement