Patient Vision Questionnaire

Name:_____ Date:_____

We recognize that your eyes are very important to you. We would like to know how ***you*** use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

Do you wear glasses now? □ Yes □ No

If yes: □ All the time □ Sometimes □ Only for distance
□ Only for reading □ Only for computer

What do you like or dislike about your current glasses?_____
_____

Do you wear contacts? □ Yes □ No If no, are you interested in contacts? □ Yes □ No

Do you wear prescription sunglasses? □ Yes □ No

Do you wear non-prescription sunglasses? □ Yes □ No

What is your occupation?_____

Do you use a computer? □ Yes □ No

If yes, how many hours average per day?_____
If yes, how far away is your computer screen from your eyes?_____

I currently have problems with:

□ Glare □ Halos around lights □ Blurred Vision □ Hazy vision

□ Headaches □ Seeing in dim light □ Poor Night Vision □ Tired eyes

What recreational hobbies and interests do you enjoy? (Check all that apply)

□ Golf □ Running □ Tennis □ Baseball

□ Boating □ Fishing □ Football □ Skiing

□ Reading □ Knitting □ Gardening □ Sewing

□ Watching TV □ Video Games □ Painting □ Internet

□ Other:_____

Please place an "X" on the following scale to describe your personality as best you can:

Easy Going Perfectionist