Name:_____ Date:_____

Do you have prescription glasses for: distance, near, sun, computer, safety, hobbies
Circle all the type(s) of glasses you have

Would you benefit from thinner, lighter lenses?	Yes	No
Are you planning to purchase new glasses today?	Yes	No
Are you interested in or have you worn lenses that darken in sunlight?	Yes	No
Are you bothered by bright light or reflection?	Yes	No
Are there times you would like not to wear glasses?	Yes	No
Are you interested in Lasik surgery or non-surgical correction of near-sightedness (CRT)?	Yes	No
Are you interested in a "test drive" of the latest contact lens designs?	Yes	No
Does your occupation require safety glasses?	Yes	No
Do you have family members in need of eyecare?	Yes	No
Do you wear glasses for sports?	Yes	No
Doctors recommend having digital images taken for the purpose of recording your internal eye appearance for future health check comparisons. This is non-invasive and provides a baseline for eye health check-ups. Images can be e-mailed to you if desired**.** (Cost is $65.00 for screening package) This is usually not covered by insurance.	Yes	No

Mark all that apply

◯ Aerobics/Fitness Walking
◯Artwork
◯Baseball/Softball
◯Basketball
◯Cycling
◯Fishing
◯Football
◯Golf
◯Handball
◯Martial Arts
◯Motorcycle
◯Other Hobbies/Sports
◯Musician
◯Racquet Sports
◯Rollerblading/Skateboarding
◯Sewing/Needlework
◯Shooting Sports
◯Skiing/Snow Sports
◯Soccer
◯Swimming
◯Volleyball
◯Water Sports/Sailing/Jet Ski

Do you have any specific vision needs or ocular concerns you would like to discuss with the doctor?
Please explain briefly: _____