LIFESTYLE AND CONTACT LENS QUESTIONNAIRE

GENERAL VISUAL DISCOMFORT

I am concerned about….
Night Vision___ Sunshine___ Computer Glare___

___Difficulty reading or doing fine print work?

___Difficulty reading computer or at arm's length?

___Difficulty seeing street signs/T.V.?

EYEWEAR

Are you satisfied with the way your glasses look/feel?_____

Are you satisfied with the vision/comfort?___

_____

Do you wear sunglasses/Polarized?_____

I AM INTERESTED IN

___ No line Bifocals (Progressives)
___ Sunglasses/Polarized
___ Lenses to Reduce Glare (Anti-Reflective)
___ Lighter, Thinner Lenses (Polycarbonate)
___ Self-darkening Lenses (Transitions)
___ Contact Lenses

OCCUPATIONAL NEEDS/HOBBIES

What is your occupation?_____ How many hours/day are you on digital devices?_____

Do you work with solvents, paint, dust, or welding? _____ Outside? _____

What are your hobbies/sports?_____

How many hours do you drive daily? _____

How does light bother you? _____

What times would you like to NOT wear your glasses? _____

CONTACT LENS QUESTIONNAIRE

What brand contact lenses do you wear? _____ How old is this pair? _____

How often do you change out your lenses (for new pair)? _____

Do you sleep in your contacts? **N / Y** If yes, how many nights/row? _____

What brand contact lens solution do you use? _____

Patient Signature: _____ ***Date***_____