

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? _____ No _____ Yes
If Yes _____ All the time _____ Sometimes
_____ Only for distance _____ Only for reading _____ Only for computer
- How important is it for you to see to read or use computer without glasses?
Very important _____ Important _____ Somewhat important _____ Not important _____
- If it were possible to go without glasses for most of the time, would you like that?
Yes _____ No _____
- How many hours per day do you: read? _____ use computer? _____
- Do you drive at night? Socially _____ Occasionally _____ As profession _____

Check the following activities you do on a regular basis:

- Read newspaper, books Read medicine bottles Needlepoint Wall Street Journal
- Drive daytime Drive nighttime Shop Golf
- Tennis Hunt or Fish Paint / Artist Cook
- Musician Play Cards / Dominos Bicycling, Roller blades, etc
- Photography Spectator Sports Movie theatre Dine in Restaurant

Underline the above activities that you would like to see without glasses if possible

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

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

Easy going Perfectionist