Name: _____ Date: _____

Please take a few minutes to answer these questions so that we can better serve your visual needs. The information you provide will help us determine the best recommendation for your vision and overall health:

Do you currently wear glasses? □ Yes □No
If yes, How often? □ All the time □ Reading only □ Distance only □ Computer only

Do you have difficulty with any of these activities, even with glasses?

Activity	**Yes**	**No**	**N/A**
Reading a book, newspaper, prescription bottle, food label or texts on your cell phone			
Writing checks or filling out forms			
Recognizing people's faces			
Doing fine work such as carpentry, sewing or crafts			
Playing games such as bingo, dominos, card games or doing word search or crossword puzzles			
Working on a computer or performing job duties			
Cooking/ reading recipes			
Watching television, reading the on screen guide, weather, sports scores and news scrolls			
Reading traffic signs, street signs, or store signs			
Driving during the day			
Driving at night			
Other:			
Please list any sports or hobbies you participate in:			

Please check any other symptoms you may be experiencing with your eyes:

□ Dry sensation □ Excess tearing (watery eyes) □ Stinging
□ Scratchy, gritty feeling □ Excessive matting □ Burning
□ Light sensitivity □ Tired or achy eyes □ Redness
□ Contact lens discomfort □ Dry flaky skin on lashes □ Soreness
□ Sensitivity to artificial tears □ Eyelids stuck together at awakening

If the doctor determines that you are an appropriate candidate for advanced technology currently available, would you like to hear more about a way to significantly reduce or possibly eliminate your need for glasses? □ Yes □ No