



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 arms 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)

OCCUPATIONAL NEEDS/HOBBIES

What is your occupation?_____ Do you work on a computer?_____ Hrs/day _____

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

What are your hobbies/sports? _____

How many hours do you drive daily? _____

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*** _____