TOTAL VISION LIFESTYLE AND EYEWEAR EVALUATION

Patient: ____

CURRENT EYEWEAR

What types of eyewear do you currently own/wear?
Please check all that apply

- ❑ Single Vision (Distance)
- ❑ Readers (Near)
- ❑ Computer Designed Lenses
- ❑ Bifocals (With-Line)
- ❑ Progressive (No-Line)
- ❑ Prescription Sunglasses
- ❑ Non -Prescription Sunglasses

VISUAL ACTIVITIES

Favorite leisure activities/hobbies/sports: ____

Occupation: ____

I use a computer, tablet or smartphone ____ hours per day

I spend significant time outdoors ❑ Yes ❑ No

I generally drive ____ hours each day and ____ hours each night

EYEWEAR PERFORMANCE

Eyewear should provide you with comfortable vision throughout the day, during all of your activities.
Please check if you experience any of the following while wearing your current eyewear.

REFLECTIONS / GLARE FROM:

- ❑ Lights while driving at night
- ❑ Indoor Lighting
- ❑ Computer or digital device screens

DIFFICULTY FOCUSING:

- ❑ Distant Objects
- ❑ Arm's Length Objects
- ❑ Near Objects

OTHER

- ❑ Sensitivity to light

LASER VISION CORRECTION

Are you interested in LASIK? ❑ Yes ❑ No

CONTACTS

Do you wear contacts?

❑ Yes ❑ No

Are you happy with the comfort?

❑ Yes ❑ No

Are you happy with the vision?

❑ Yes ❑ No

What do you like about your current eyewear?

____

____

*Is there **anything** about the performance of your current eyewear or contact lenses you don't like or would change?*

____

____

____