

Occupation: \_\_\_\_\_

1. Which of the following visual demands do you encounter on a regular basis?  
(Check all that apply)

- |                                              |                                                 |                                           |
|----------------------------------------------|-------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Reading small print | <input type="checkbox"/> Fine / close-up work   | <input type="checkbox"/> Outdoors         |
| <input type="checkbox"/> Artificial lighting | <input type="checkbox"/> Classroom / board work | <input type="checkbox"/> Natural lighting |
| <input type="checkbox"/> Computer work       | <input type="checkbox"/> Potential eye hazards  |                                           |

2. How much time do you spend on a computer daily?

- None       1-2 hrs.       3-6 hrs.       More

3. Which of the following hobbies or activities do you participate in? (Check all that apply)

- |                                                   |                                                |                                                    |
|---------------------------------------------------|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Art / Painting / Drawing | <input type="checkbox"/> Hunting / Shooting    | <input type="checkbox"/> Soccer                    |
| <input type="checkbox"/> Baseball / Softball      | <input type="checkbox"/> Jogging / Running     | <input type="checkbox"/> Swimming                  |
| <input type="checkbox"/> Biking                   | <input type="checkbox"/> Musical Instrument    | <input type="checkbox"/> Tennis                    |
| <input type="checkbox"/> Boating / Water sports   | <input type="checkbox"/> Pilot                 | <input type="checkbox"/> Travel                    |
| <input type="checkbox"/> Driving                  | <input type="checkbox"/> Racquetball           | <input type="checkbox"/> Watching TV               |
| <input type="checkbox"/> Exercise                 | <input type="checkbox"/> Reading               | <input type="checkbox"/> Welding                   |
| <input type="checkbox"/> Fishing                  | <input type="checkbox"/> Sewing / Crafts       | <input type="checkbox"/> Woodworking/<br>Carpentry |
| <input type="checkbox"/> Golf                     | <input type="checkbox"/> Skiing / Snowboarding |                                                    |

4. How many pairs of prescription eyeglasses do you currently use? \_\_\_\_\_

What do you like or dislike about your current eyeglasses?  
(weight, thickness, style, etc)

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5. Do you have prescription sunglasses?  yes       no

6. Are you bothered by bright light, reflections, or glare?  yes       no

7. Do you have difficulty when driving at night?  yes       no

8. Do you wear contact lenses?  yes       no

What do you like or dislike about your current contact lenses?  
(vision, comfort, color, etc)

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9. How did you hear about our practice? \_\_\_\_\_