Name: ______________________________ Date: ____________

Diagnostic Issues

Please list any complaints about wearing glasses or contacts: ____________________

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- Do you work in an environment or play a sport where safety is an issue? .... No Yes
- Do you have more than 1 pr. of current Rx glasses? .... No Yes
- Do you work on a computer for long periods? .... No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? .... No Yes
- Do you spend a lot of time outdoors? .... No Yes
- If you wear bifocals, are you bothered by restricted windows, lines, or head tilting? .... No Yes
- Are there times you'd rather not wear glasses? .... No Yes
- If you wear contact lenses, are you satisfied with vision and comfort? .... No Yes
- Are you interested in a "test drive" of the latest in contact lens design (s)? .... No Yes
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? .... No Yes

Do You Experience...

Any discomfort with your eyes? .... No Yes

Problems with glare or reflection? .... No Yes

Sensitivity to light? .... No Yes

Headaches? .... No Yes

Floaters or flashes of light? .... No Yes