



Name: _____ Date: _____

Diagnostic Issues

Please list any complaints about wearing glasses or contacts: _____

- 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