Vision Consultation Questionnaire

Please **answer or circle "Yes" or "No"** for the following questions:

How many hours per day do you work on the computer?	___ hours
How much time do you spend outdoors in the sun each week?	___ hours
Do you need updated sunglasses (with or without prescription) to help protect your eyes from harmful UV light and to prevent Cataracts and Macular Degeneration?	Yes / No
Do you need a **back-up pair** of prescription glasses? (For example, in case your current glasses are lost, or broken, or if there is an emergency such as a fire or earthquake)	Yes / No
Do you need a **spare pair** of RGP (Rigid Gas Permeable) contact lenses?	Yes / No
Do you need **Safety glasses** for work?	Yes / No
Do you have **Children** in need of an eye examination?	Yes / No
Do you have **Family Members** in need of an eye examination?	Yes / No
Are you interested in LASIK?	Yes / No
Are you interested in a Non-Surgical approach to vision correction (CRT / Ortho-K)?	Yes / No
Are you interested in thinner, lighter lenses in your glasses?	Yes / No
Are you interested in single use soft contact lenses (No cleaning necessary)?	Yes / No
Are you interested in Bifocal Contact Lenses?	Yes / No
Are you interested in Photochromic/Transition glasses? (lenses that change colors indoors and outdoors)	Yes / No
Did you receive a Recall Post Card?	Yes / No

Which activities or hobbies do you enjoy? (Please circle all that may apply)

Baseball	Basketball	Biking	Boxing	Card Playing
Computers	Dancing	Driving	Fishing	Flying
Football	Gardening	Golfing	Hiking	Hula
Hunting	Jogging	Movies	Musical Instruments	Outdoor activities
Photography	Pool / Billiards	Racquetball	Reading	Scuba Diving
Sewing	Shooting	Skiing	Snowboarding	Soccer
Surfing	Swimming	Television	Tennis	Theatre
Video Games	Volleyball	Walking	Water Sports	Wrestling