PATIENT HISTORY AND LIFESTYLE QUESTIONAIRE

FAMILY HISTORY OF GLAUCOMA? YES NO

FAMILY HISTORY OF MACULAR DEGENERATION? YES NO

FAMILY HISTORY OF RETINAL DETACHMENT? YES NO

FAMILY HISTORY OF LAZY EYE? YES NO

FAMILY HISTORY OF DIABETES? YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH AN EYE DISEASE? YES NO

HAVE YOU EVER HAD EYE SURGERY? YES NO

DO YOU FREQUENTLY GET HEADACHES? YES NO

HAVE YOU EVER HAD AN EYE INJURY? YES NO

DO YOU CURRENTLY WEAR CONTACT LENSES? YES NO

DO YOU HAVE ANY INTEREST IN WEARING CONTACT LENSES YES NO

ARE YOU FREQUENTLY BOTHERED BY DRY, IRRITATED EYES? YES NO

DO ALLERGIES FREQUENTLY AFFECT YOUR EYES? YES NO

DO YOU EXPERIENCE GLARE WITH NIGHT DRIVING? YES NO

DO YOU EXPERIENCE EYESTRAIN WITH COMPUTER USE? YES NO

APPROXIMATELY HOW MANY HOURS A DAY DO YOU SPEND ON A COMPUTER?_____

WHAT TYPES OF LEISURE ACTIVITIES DO YOU HAVE INTEREST?_____

WHAT DID YOU LIKE ABOUT YOUR LAST PAIR OF GLASSES?_____

_____

WHAT WOULD YOU CHANGE ABOUT YOUR LAST PAIR OF GLASSES?_____

ARE YOU CONCERNED ABOUT UV/BLUE LIGHT PROTECTION? YES NO

DO YOU CURRENTLY WEAR PRESCRIPTION SUNGLASSES? YES NO

DO YOU HAVE ANY INTEREST IN LASER VISION CORRECTION? YES NO

DESIRED METHOD OF PAYMENT : CASH CHECK CREDIT CARD

ASK ABOUT 50% SAVNGS ON SECOND PAIRS OF GLASSES!!