



& LASIK SURGERY

Patient Name: _____ Date of Visit: _____

Occupation: _____

This questionnaire is designed to assist you and your eye care professional in helping select the best lenses, frames and/or contact lenses to suit your visual needs and lifestyle. Take a few moments to answer the following questions or work with your eye care professional to answer them together.

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

- Artificial lighting
- Board work
- Close-up work
- Computer work
- Natural lighting
- Paperwork
- Potential eye hazards
- Reading
- Other:

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

- Auto repair
- Biking
- Boating/water sports
- Bookkeeping
- Bowling
- Competitive sports
- Computer
- Drawing
- Driving
- Exercise
- Fishing
- Golf
- Home repairs
- Hunting/shooting
- Jogging/running
- Landscaping/gardening
- Musical instrument
- Painting
- Pilot
- Racquetball
- Reading
- Sewing/arts/crafts
- Snow sports
- Spectator sports
- Tennis
- Watching TV
- Welding
- Woodwork
- Other:

Do your eyes seem bothered by glare from any of the following situations?

- Car headlights
- Computer monitor
- Fluorescent lights
- Haze
- Night driving
- Sunshine
- Traffic lights
- Other:

If you wear contacts, do you have: (Check all that apply)

- Current pair of prescription glasses
- Sunglasses (purchased at a boutique, department/optical store)
- Other:

Do you have any metal or silicon allergies?

- Yes
- No

What do you like about your current glasses or contacts (color, style, fit, etc.)?

What don't you like about your current glasses or contacts (weight, thickness, glare, etc.)?
