Clinical Vision Evaluation Form

To provide you with the best vision possible, we need to know a little more about you. Please fill in the blanks below regarding your vision needs.

Name_______________________________________ Date______________________

Are you having Vision difficulties at:  Work  School   Play   Other ______________

Occupation:_____________ List your favorite hobbies:__________________________

When spending time?

- Outdoors  Any concerns with: Glare   Sunlight   Safety   Health
- Driving   Any concerns with: Glare   Sunlight   Night vision
- Playing sports  Any concerns with: Safety   Sunlight   Durability
- Computer / TV Any concerns with: Glare   Eyestrain   Focus

Are your eyes sensitive to sunlight?      yes      no
Do you currently have sunglasses?      yes      no
Do you currently wear or interested in contact lenses?    yes      no
If you wear contact lenses do you have glasses?    yes      no

If you currently wear glasses, what would you change about them?

<table>
<thead>
<tr>
<th>Style</th>
<th>More comfort</th>
<th>Thinner Lenses</th>
<th>Safer</th>
<th>Lenses that Change Color</th>
<th>Sun protection</th>
<th>Less Glare</th>
<th>More durable</th>
<th>Invisible Bifocal</th>
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For Doctors Use Only

Your Vision Treatment Plan:

1. Primary Glasses

2. Sunglasses

3. Computer Glasses

4. Reading Glasses

5. Sports Glasses

Specialty Glasses / Contact lenses