Date: _____ Patient Name: _____

List any previous surgeries and dates if known: _____

_____

_____

Are you pregnant or nursing: Yes No

Visual Needs Assessment:

Do you wear Glasses: Yes No

Do you wear Contact Lenses: Yes No

Are you interested in Contact Lenses: Yes No

Are you sensitive to light: Yes No

Hours of computer usage per day: _____

Hours of outdoor activity per day: _____

Hobbies/Recreation: _____

How many hours do you read before you experience fatigue: _____

Are you bothered by glare from: Overhead lighting/Computer Screens/Oncoming headlights at night while driving: Yes No

Circle if you have: eyestrain headaches trouble with night driving

Patient's Ocular History:

List any previous eye surgeries and dates if known: _____

_____

(Circle yes or no to each entry)

Macular degeneration:	Yes	No	Amblyopia:	Yes	No
Blindness in one or both eyes:	Yes	No	Cataracts:	Yes	No
Injury to the eye region:	Yes	No	Glaucoma:	Yes	No
Keratoconus:	Yes	No	Retinopathy:	Yes	No