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	□ Interested
Do you currently wear contact lenses?	□ yes	□ no	□ Interested
If you wear contact lenses, do you have glasses?	□ yes	□ no	
If you wear contact lenses, do you sleep in them?	□ yes	□ no	
Would you be interested in CLs you don't have to clean?	□ yes	□ no	
How many hours per day do you spend on a computer	_____		

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

□ Style □More comfort □Thinner Lenses □Safer □Lenses that Change Color
□Sun protection □Less Glare □More durable □Invisible Bifocal

For Doctors Use Only

Your Vision Treatment Plan:

1. Primary Glasses

_____

_____

_____

2. Sunglasses

_____

_____

_____

3. Computer Glasses

_____

_____

_____

4. Reading Glasses

_____

_____

_____

5. Sports Glasses

_____

_____

_____

6. Specialty Glasses / Contact lenses

_____

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