

Vision Care

To help us better assist you today, please provide us with the following updated information.

Date _____

Name _____

Address _____

Home Phone _____

Work _____

Cell _____

City/State _____ Zip Code _____

Preferred contact number:

- Home
- Work
- Cell

Email Address _____

What is your Occupation? _____

Are you interested in purchasing glasses or prescription sunglasses today?

- Yes
- No

Are you experiencing any of the following?

- Headaches
- Sensitivity to light
- Poor near vision
- Poor distance vision
- Eye irritation
- Glare (circle all that apply)
 - Computer monitor,
 - Night driving,
 - Florescent lighting,
 - Cell phone,
 - Television

Please rate your eye strain/fatigue on a scale of 1-10, 10 being the worst.

To further assist your needs, please circle the appropriate answer:

- | | | |
|--|---|---|
| <input type="checkbox"/> Are you on a computer more than 4 hours per day? | Y | N |
| <input type="checkbox"/> Do you use your near vision more than 4 hours a day? (Texting, reading, etc.) | Y | N |
| <input type="checkbox"/> Do you participate in any water sports? (Fishing, skiing, etc.) | Y | N |
| <input type="checkbox"/> Do any of your recreational hobbies include flying, golfing, hiking, or biking? | Y | N |

Please list any additional comments or changes in medical history, including new medications:

Visual Field Test:

A new computerized instrument now enables us to check for areas of loss of sight in the central (straight ahead) and peripheral (side view) areas. **It can detect early signs of glaucoma, retinal problems, neurological diseases, macular disorders and headache related illnesses.**

We strongly recommend our patients receive this test in addition to their comprehensive visual analysis. The fee for the test is \$30.00.

Would you like to receive this test?

- Yes
- No