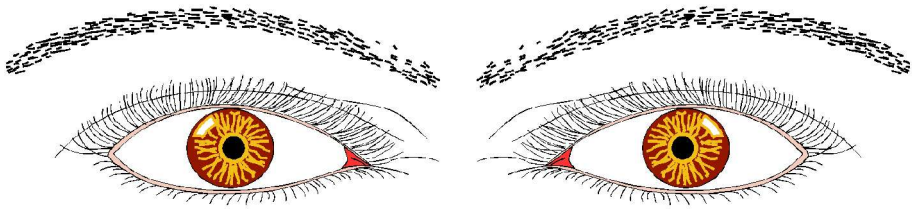

For Your Eyes Only

Patient Name:_____ Date: _____

- Are you bothered by sunlight? ☐ Yes ☐ No
- Does night driving bother you? ☐ Yes ☐ No
- Do you want to know more about Contact Lenses? ☐ Yes ☐ No

Your Eyewear Needs	
◯ Daily Wear	◯ Business
◯ Dress Up	◯ Sports
◯ Driving	◯ Sunglasses
◯ Reading Only	◯ Light Sensitive Lenses
◯ Other _____	

Occupational Needs	
◯ Computer Terminal	◯ Top & Bottom Bifocal
◯ Protective Industrial	◯ Very Wide Bifocal
◯ Special Absorption (X-Rays, UV, Lasers)	
◯ Special Frames (Side Shields, etc.)	
◯ Other _____	

Hobbies You Enjoy	
◯ Home Workshop	◯ Needlework, Knitting, etc.
◯ Stamp or Coin Collection	◯ Card Playing
◯ Drawing, Painting, etc.	◯ Computer Games
◯ Other _____	

Sports in Which You Participate	
◯ Racquetball, Tennis, etc.	◯ Scuba, Swimming, etc.
◯ Boating	◯ Shooting, Hunting, etc.
◯ Contact Sports	◯ Skiing
◯ Jogging or Cycling	◯ Golf

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