

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORYDo you use a computer? Yes No How many hours/day? _____ Distance from Computer? _____Do you drive? Yes No Mileage to work each way? _____ Do you have glare problems? Yes NoDo you have visual difficulty when driving? Yes NoDo you have problems with night vision? Yes NoDo you currently wear glasses ? Yes No Since _____Type of glasses Full Time Part Time Distance Close

Glasses Owned

 Single Vision Bifocals Trifocals Back-up Glasses Safety Glasses Sports Glasses ProgressiveHave you had trouble in the past with glasses? Yes No _____Do you wear sunglasses? Yes No Are your sun glasses your current prescription ? Yes No**SPECIAL EYEWEAR NEEDS** Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding) Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)**CONTACT LENS HISTORY**Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____Do you currently wear contact lenses? Yes No Since _____If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORYDo you use nutritional supplements (vitamins etc.)? Yes NoDo you engage in regular exercise? Yes NoDo you drink alcohol ? If yes, how much/often : No Occasional 1 per day 2-3/day 4+/dayDo you smoke ? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ packMethod of Tobacco Intake : Smoking ChewingDo you use Illegal Drugs : Yes No

Hobbies/ Interests : _____