

## PATIENT QUESTIONNAIRE

	Never	Some	Often
Do you have trouble changing your focus from near to far, or vice versa?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you spend time outside or driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you spend time in front of screens (phone, tablet, Kindle, TV, computer)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you notice sensitivity to bright lights, glare, or fluorescent lighting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems seeing with your current eyewear and/or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wish your glasses were:			
Thinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lighter Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More Durable/Scratch Resistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in eye surgery (Lasik, other)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you experienced difficulty hearing when:			
Holding a conversation in noisy environments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching television or listening to the radio at a moderate volume?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in group discussions or meetings due to being unable to hear all parts of the conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other concerns you would like to discuss today regarding your vision, eye health, or eyewear needs?