

INDIVIDUAL EYES

Lenses as individual as you

Name: _____ **Date:** _____

Occupation:

- | | | | |
|----------------------------------|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Office | <input type="checkbox"/> Construction | <input type="checkbox"/> Mechanic | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Driving | <input type="checkbox"/> Computer Field | <input type="checkbox"/> Other _____ |

Are you bothered by glare from any of the following?

- | | | | |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> Night Driving | <input type="checkbox"/> Sunshine | <input type="checkbox"/> Fluorescent Lights | <input type="checkbox"/> Computer Screen |
|--|-----------------------------------|---|--|

Hobbies:

- | | | | |
|---------------------------------|--|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Golf | <input type="checkbox"/> Fishing/Hunting | <input type="checkbox"/> Skiing | <input type="checkbox"/> Cycling |
| <input type="checkbox"/> Sewing | <input type="checkbox"/> Hiking/Biking | <input type="checkbox"/> Reading | <input type="checkbox"/> Other _____ |

How many hours per week do you spend:

- | | | | |
|--------------------------|-------------------------------|--------------------------------|------------------------------|
| On a computer | <input type="checkbox"/> 0-10 | <input type="checkbox"/> 11-20 | <input type="checkbox"/> 20+ |
| Outdoors | <input type="checkbox"/> 0-10 | <input type="checkbox"/> 11-20 | <input type="checkbox"/> 20+ |
| Driving/Daytime | <input type="checkbox"/> 0-10 | <input type="checkbox"/> 11-20 | <input type="checkbox"/> 20+ |
| Driving/Nighttime | <input type="checkbox"/> 0-10 | <input type="checkbox"/> 11-20 | <input type="checkbox"/> 20+ |
| Participating in Hobbies | <input type="checkbox"/> 0-10 | <input type="checkbox"/> 11-20 | <input type="checkbox"/> 20+ |

At work, do you read small print?

- Yes
 No

Are your eyes sensitive to sunlight?

- Yes
 No

Do you perform fine or close-up work?

- Yes
 No

Do you have trouble reading?

- Yes
 No

Is safety protection a concern?

- Yes
 No

Do you have trouble reading signs at night while driving?

- Yes
 No

Do you have prescription sunglasses?

- Yes
 No

Are you interested in, or have you worn, glasses that darken in the sunlight?

- Yes
 No

If Yes, are they polarized?

- Yes
 No

How many pairs of glasses do you currently use?

- 1 2 3+

What do you like most about your current glasses? _____

What do you like least about your current glasses? _____