Clinical Vision Evaluation Form

Every year, a patient's needs change. We value you as a patient and to provide you with the best vision care, we need to know a little more about you. Thank you for trusting us with your vision!

Name _____ Date _____

HOME PHONE (____)_____-_____ OCCUPATION: _____

CELL PHONE (____)_____-_____ EMAIL _____ @ _____._____

To ensure that your family and friends experience the same level of patient convenience and satisfaction that you will receive today, is there anyone you know that could benefit from a visit to see our doctors and staff?

Name(s) _____ Contact Number _____ Initial for consent to contact _____

Name(s) _____ Contact Number _____ Initial for consent to contact _____

How much time per day do you spend on **Digital Devices** including: phones, tablets, computers or Televisions?

Please circle one: 2 – 4 hours 4 – 8 hours 8 – more than 12 hours

EYE GLASSES

If you currently wear glasses, what would you change about the lenses or frames?

PLEASE CHECK BOXES BELOW:

- □ Lighter
- □ Style of Frames
- □ Lenses that Change Color
- □ Less Glare
- □ Easy-To-Clean
- □ Thinner Lenses
- □ Invisible Bifocal
- □ Sun Protection
- □ Scratch Resistant
- □ More Durable

CONTACT LENSES

PLEASE CHECK BOXES BELOW:

Do you currently wear contact lenses?

□ yes □ no □ interested?

If yes, are you wearing them today?

□ yes □ no

On a scale of 1 to 10, rate your contact lenses

Comfort: 1 2 3 4 5 6 7 8 9 10

Clarity: 1 2 3 4 5 6 7 8 9 10

Our patients' privacy is extremely important to us. If you would like to receive a copy of our privacy policy that illustrates the steps we have implemented to protect our patients' privacy, please simply make that request to our front desk staff.

CLINIC QUESTIONS : TO BE FILLED OUT BY CLINIC TECHNICIAN

EYE GLASSES

1. Driving, Challenges with: □ Halos at Night □ Glare □ Sun
2. Rate your **Eye Strain** at the end of a typical day from Digital Devices: □ Moderate □ Severe □ Mild
3. Do you wear prescription sunglasses? □ Yes □ No
4. Ever Find a time when Glasses are inconvenient ? □ Yes □ No

DRY EYES

On a scale of 1-10 please rate your Comfort:

Itchiness /Redness: 1 2 3 4 5 6 7 8 9 10

Dryness: 1 2 3 4 5 6 7 8 9 10

Your Custom Vision Treatment Plan:

_____

_____

For Doctors Use Only

1. Primary Indoor Glasses

□ Style - Chance to Update Frames! _

□ Lenses that Change Color (□ Grey □ Brown □ Green)

□ Easy-To-Clean – Premium Non-Glare

□ More Durable □ Invisible Bifocal

□ Lighter □ Thinner Lenses

2. Primary Outdoor Glasses

□ Sun Protection – SLIGHT RX CHANGE □

□ Lenses that Change Color

□ Easy-To-Clean – Premium Non-Glare

□ Fishing Glasses

□ BEACH READERS

3. Computer Glasses/Reading Glasses

(We have 4 Different Computer Lenses)

□ Space (Small Computer Area to Full Distance)

□ Screen (LARGE Computer – Small Full Distance)

□ Zoom (LARGE NEAR – Smaller Computer)

□ SYNC Single Vision with BOOST

.5 .9 1.3

<35 35 – 40 > 40 PT Age

4. Sport Glasses / Contact Lenses /

□ One box per eye of Disposable Contacts

□ Cycling Glasses

□ Shooting Glasses

□ Lenses for the Golf Course

□ Basic Backup Glasses w/ BASIC AR

□ Basic Backup FASHION READERS

Y N Clinic INT

For Optical Use Only **1** **2** **3** **4** **5** **WA** **DT** **VO**

C E S M Optician_____ Amt_____

Rsn_____

Date_____INT_____