McClurg Vision Center

Name: _____ Date: _____ Age:_____

1. When was your last eye exam?

_____ Less than 1 year _____ Less than 2 years _____ Over 2 years _____ Never

2. What is the reason for your visit today?

Glasses Wearers:

1. Are you interested in purchasing glasses today? Yes No

   If yes, please list these options in order of importance:
   Comfort Price Style

2. Are you interested in switching to contacts? Yes No

Contact Lens Wearers:

1. Are your contacts on today? Yes No
2. How do your lenses feel when you first put them in?
3. How do they feel right before you take them out?
4. About how many hours a day do you wear your contacts?
5. Do you have a pair of back up glasses? Yes No
6. Are you interested in switching to glasses? Yes No