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Eyeglass Wearers:

1. If you could change something about your glasses, what would it be? (Lighter weight, darkens when you're outside, etc.)

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

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Contact Lens Wearers:

1. Are your contacts on today? Yes No

2. How do your lenses feel when you first put them in? _____

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4. About how many hours a day do you wear your contacts? _____

5. Do you have a pair of back up glasses? Yes No

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Never Rarely Often Daily

2. How often are your eyes/vision uncomfortable after hours of looking at a computer screen?

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3. Do you get tired eyes, dry eyes, or light sensitivity throughout the day? Yes No

If yes, please explain. _____

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4. Do you get motion sickness or experience dizziness or vertigo with certain activities? Yes No

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7. How would you rate your hearing from 1-10? (10 being excellent) _____

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Name: _____ Email: _____

Date_____ Age: _____

1. When was your last eye exam? _____

2. What is the reason for your visit? _____

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Eyeglass Wearers:

1. If you could change something about your glasses, what would it be? (Lighter weight, darkens when you're outside, etc.)

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

3. If not a contact wearer, are you interested in trying 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

Lifestyle Questionnaire:

1. How often do you experience migraine-like symptoms?

Never Rarely Often Daily

2. How often are your eyes/vision uncomfortable after hours of looking at a computer screen?

Never Rarely Often Daily

3. Do you get tired eyes, dry eyes, or light sensitivity throughout the day? Yes No

If yes, please explain. _____

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4. Do you get motion sickness or experience dizziness or vertigo with certain activities? Yes No

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