# Clinical Vision Evaluation Form

To provide you with the best vision possible, we need to know a little more about you.
Please fill in the blanks below regarding your vision needs.

Name:_____ Date:_____

Are you having difficulties at: []Work []School []Play other:_____

Occupation:_____ List your hobbies:_____

Do you spend any time?

| | | | | | | |
|---|---|---|---|---|---|---|
| Outdoors | [] yes | Any concerns with: | [] Glare | []Sunlight | []Safety | []Health |
| Driving | [] yes | Any concerns with: | [] Glare | []Sunlight | []Night Vision | |
| Playing Sports | [] yes | Any concerns with: | [] Safety | []Sunlight | []Durability | |
| Computer/TV | [] yes | Any concerns with: | [] Glare | []Eyestrain | []Focus | |

| | | | |
|---|---|---|---|
| Are your eyes sensitive to sunlight? | []yes | []no | []Interested in sunglasses? |
| Do you wear contact lenses? | []yes | []no | []Interested? |
| (If yes, do you have a primary correction? Aka. glasses) | []yes | []no | |

If you currently wear glasses, what would you change about them?

| | | | |
|---|---|---|---|
| [] Style | [] More Comfort | []Thinner Lenses | []Safer |
| [] Sun protection | [] Less Glare | []More durable | [] Invisible Bifocal? |