



Name _____

Age _____ Occupation _____

How often and for how long a time do you wear your glasses?

Do you wear contact lenses? _____ How many hours? _____

Do you have a backup pair of glasses? _____

What do you like most about your previous eyewear? _____

What do you like least about your previous eyewear? _____

Do you drive? _____ At night? _____

Do you ever have problems with glare? _____

Do you have problems with bright sunlight? _____

Do you have prescription sunglasses? _____

How often do you wear them? _____

Do you work at a computer? _____ How many hours a day? _____

What kind of recreational activities are you involved in? _____

What kind of sports do you play and how often do you play them? _____

Do you have any hobbies? _____

Do you have any specific visual challenges at work? _____

Doctor's Recommendations: _____

Eyewear to “Best Fit” all the people you are

