

What are Your *Visual Needs?*

Patient Name _____

Computer Issues

1. _____ Hours spent at computer daily.
2. Lighting in work area is:
 low average bright
3. Are you experiencing any of the following symptoms while at your computer monitor?
 headaches
 blurred vision
 glare (light) sensitivity
4. Do you wear glasses or contacts while working at the computer?
 YES NO
5. Do you view books/text material while working at the computer?
 YES NO

Approximate Viewing Distances/Direction *(very helpful)*

6. Viewing distance *(eye to computer screen)* is
 arms length longer than arms length
7. Viewing distance *(eye to reference material)* is
 arms length longer than arms length
8. The center of the computer screen is (circle one)
 above eye level
 equal to eye level
 below eye level
9. Book/ text material is
 on the desk same height as computer screen

10. What do you like or dislike the most about your current pair of glasses?

Lifestyle Issues

11. Check the feature that is most important to you in a frame.
 function comfort brand name fashion



12. What glasses do you currently use?
 general sunglasses work/hobby spare pair
13. If possible would you like your lenses to be thinner and lighter?
 YES NO
14. Do your activities cause you to go indoors and outdoors frequently?
 YES NO
15. Do you do any activities on the
 sand water snow
16. Have you ever tried progressive lenses?
 YES NO
17. Are you bothered by:
Problems with glare or reflection?
During the day? YES NO
Driving at Night? YES NO
18. Do you have sensitivity to light?
 YES NO

Safety Issues

19. Do you do home improvement projects?
 YES NO
20. Do you use power tools?
 YES NO
21. Do you participate in any sports?
 YES NO



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