
Vision Needs Checklist

Patient Name _____ Date _____

1. Are you generally satisfied with the eyeglasses you're now wearing?

YES _____ NO _____

2. Do you experience any eye *strain* under the following conditions?

Please check all that apply:

- Artificial/fluorescent lighting
- Reading
- Computer work
- Paperwork
- Car headlights
- Hazy conditions
- Night driving
- Bright sunshine
- Snow
- Other _____

3. In what *Recreational* activities do you participate?

Please check all that apply:

- Swimming/Diving
- Golf
- Cycling
- Hunting/Shooting
- Driving
- Jogging/Running
- Skiing/Snowboarding
- Boating/Fishing
- Other _____

continued on back

4. In what *Sports* activities do you participate?

Please check all that apply:

- Basketball
- Soccer
- Lacrosse
- Racquet sports
- Tennis
- Other _____

5. Are you involved in an *Occupation* where there is potential risk to eye health such as:

- Auto Repair
- Landscaping
- Painting/Carpentry
- Health Care
- Utilities
- Electrical
- Health Care
- Construction
- Other _____

6. Are there specific products you've become aware of since your last visit that you'd like to learn more about?

Please list:

Thank you