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WOLF EYE CENTER
YOU'LL SEE THE DIFFERENCE! INC

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YOU'LL SEE THE DIFFERENCE!

Patient Name: _____Date:_____Chart#_____

WE WOULD LIKE TO KNOW HOW YOU USE YOUR EYES! Along with your eye exam, this information will help us recommend the best options for your eyes and your lifestyle.

1. **Do you wear glasses now?** ☐ Yes ☐ No **If yes how often?** ☐ All the time ☐ Sometimes ☐ Only for distance ☐ Only for reading ☐ Only for computer ☐ Other
2. **Do you mind wearing glasses?** ☐ Yes ☐ No
3. **What do you like about your current glasses?** ☐ Style ☐ Comfort ☐ Tinting ☐ Clarity ☐ Glare reduction ☐ Scratch resistance ☐ Other _____
4. **What do you dislike about your current glasses?** _____
5. **Do you own prescription sunglasses?** ☐ Yes ☐ No
6. **Do you own prescription computer/reading glasses?** ☐ Yes ☐ No
7. **Do you wear or have you ever worn contact lenses?** ☐ Yes ☐ No **If yes, what type?** ☐ Single vision ☐ Multifocal ☐ Monovision ☐ Other **If you no longer wear contacts, why did you stop?** _____
8. **How many hours per day do you:** Read_____ Use computer_____ Drive _____
9. **Where do you hold a book when reading?** ☐ Close to face ☐ Chest level ☐ In lap
10. **What type of computer do you use?** ☐ Desktop ☐ Laptop ☐ Tablet ☐ Smartphone
11. **Do you have eyewear to protect your eyes from injury while working and playing?** ☐ Yes ☐ No
12. **Please check any of the following items that are giving you trouble with your vision:**

    ☐ Bright lighting/glare ☐ Failed DMV test ☐ Night driving ☐ Tolerating glasses

    ☐ Using eyes together ☐ Double vision ☐ Close work ☐ Depth perception

13. **What activities, sports, and hobbies do you enjoy doing most?** _____

_____

Please place an "X" on the following scale to best describe your personality

Easy going _____Perfectionist