LIFETIME EYECARE
YOUR VISION SOURCE

Welcome to Our Office ____________________________!

To insure we prescribe everything you need for your eyes today we want to know how you use your eyes and how they feel.

Top three activities you are involved in or spend your time doing:

____________________ ____________________ ____________________

How much time do you spend on a computer/cell phone/playing video games/I pad/tablet?

☐0-2 Hours per Day ☐2-4 Hours per Day ☐More than 4 Hours per Day

Do you wear contact lenses?	☐Yes	☐No
If so do you have current glasses?	☐Yes	☐No
If so do you have polarized sunglasses?	☐Yes	☐No

Rate the comfort of your eyes between **5 (most comfortable) and 1(uncomfortable):**

1 2 3 4 5

Do your eyes feel dry?	☐Yes	☐No
Do your eyes ever get blurry?	☐Yes	☐No
Do you use eye drops?	☐Yes	☐No
Do your eyes ever itch/burn/water?	☐Yes	☐No
Do you currently take fish oil?	☐Yes	☐No
Do you have concerns about the lines/puffiness around your eyes?	☐Yes	☐No
How much time do you spend outside	☐Less	☐More than two hours.
Do you have polarized sunglasses?	☐Yes	☐No
Do you wish to update your glasses today?	☐Yes	☐No

Do you have any other concerns about your eyes?__________________________________