

Your Vision Lifestyle

In order to make your visit with us as beneficial as possible, we ask that you fill out this form with accuracy. We will use this information you provide to streamline the visit to better meet your visual needs.

Dr. Shannon Clark Leitenbauer and Dr. Kelly Jacobi

PATIENT'S NAME: _____ **Date:** _____

Date of Birth: ___/___/___

SPECTACLE HISTORY:

Please circle how often you currently wear the following forms of sight correction and/or sight protection....

Contact Lenses	Always	Often	Rarely	Never
Eyeglasses	Always	Often	Rarely	Never
Prescription	Always	Often	Rarely	Never
Sunglasses				
Non-prescription	Always	Often	Rarely	Never
Safety Glasses	Always	Often	Rarely	Never
Computer Glasses	Always	Often	Rarely	Never

If you are not currently a contact lens wearer, are you interested in trying them at this time? yes / no

Your eyewear is a part of your life! It should function perfectly, look great, and always feel completely comfortable. Do you have any of the following problems with your current eyewear? (check all that apply)

- Too heavy (they leave marks on nose or cheeks)
- Poor fit (they slip down or are uneven)
- Squeeze too hard at or around your ears
- Wrong size (too large or too small)
- Difficulty with using the bifocal and/or trifocal
- Too much glare
- Irritating under fluorescent lights
- Inadequate amount of reading area in the lenses
- Need constant adjustment
- Outdated, faded or worn out
- Screws fall out too easily
- Other, please comment: _____

Knowing what you use your eyes for is important in helping us to determine what the best kind of sight correction would be for you and your daily like/activities. Please circle your participation level in the following activities:

Reading	Always	Often	Rarely	Never
Computer	Always	Often	Rarely	Never
Television	Always	Often	Rarely	Never
Golf	Always	Often	Rarely	Never
Jogging	Always	Often	Rarely	Never
Tennis	Always	Often	Rarely	Never
Water Sports	Always	Often	Rarely	Never
Other:	_____			

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