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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! 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. **What do you like about your current glasses?** ☐ Style ☐ Comfort ☐ Tinting ☐ Clarity ☐ Glare reduction ☐ Scratch resistance ☐ Other _____
3. **What do you dislike about your current glasses?** _____
4. **Where do you hold a book when reading?** ☐ Close to face ☐ Chest level ☐ In lap
5. **What type of computer do you use?** ☐ Desktop ☐ Laptop ☐ Tablet ☐ Smartphone
6. **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

7. **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