

ADDITIONAL INFORMATION

(ALL INFORMATION IS CONFIDENTIAL)

SPOUSE, PARENT, OR GUARDIAN _____

EMPLOYER _____

ADDRESS _____

OCCUPATION _____ WORK PHONE _____

PARENTS, CHILDREN OR SIBLINGS (AT HOME)

BIRTHDATE

_____	_____
_____	_____
_____	_____
_____	_____

DEMOGRAPHICS & OTHER INFORMATION

Current Weight: _____ lbs. *Current Height:* _____ feet _____ inches

Preferred Language: English other (please list): _____

- Race:* American Indian or Alaskan Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White
 All other races
 Prefer not to answer

- Ethnicity:* Hispanic or Latino
 Not Hispanic or Latino

REASON FOR EXAMINATION

- | | |
|--|---|
| <input type="checkbox"/> Annual Checkup | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> New Frame or Lenses Needed | <input type="checkbox"/> Eyestrain |
| <input type="checkbox"/> Prescription Sunglasses Desired | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Non-Prescription Sunglasses | <input type="checkbox"/> Severe Sensitivity to Lights |
| <input type="checkbox"/> Computer Glasses | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Reading Glasses | <input type="checkbox"/> Poor Night Vision |
| <input type="checkbox"/> Sport Glasses | <input type="checkbox"/> Bothersome Night Glare |
| <input type="checkbox"/> Contact Lenses Desired | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Redness | <input type="checkbox"/> Total Loss of Vision |
| <input type="checkbox"/> Eye Burn | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eyes Itch | |
| <input type="checkbox"/> Tearing | |
| <input type="checkbox"/> Eye Discharge | |

OCCUPATIONAL

- Protective industrial safety lenses
 Computer: How many hours/day? _____ Laptop Desktop Tablet
(circle all that apply)

PERFORMANCE & OUTDOOR

- | | |
|---|---|
| <input type="checkbox"/> Poor Reading Skills or Performance | <input type="checkbox"/> Extended Night Driving |
| <input type="checkbox"/> Inconsistent Sports Vision Performance | <input type="checkbox"/> Outdoors in Direct UV exposure |
| <input type="checkbox"/> Slowness When Shifting Focus | <input type="checkbox"/> Read in Outdoor Settings |
| <input type="checkbox"/> Difficulty with 3-D Images, Movies or TV | <input type="checkbox"/> Other _____ |