

Vision Customization Form



Patient Name _____ Date of Birth _____

Please tell us about yourself to guide the vision customization planning process

- Occupation: _____
- Activities / hobbies (check all that apply):

Distance Vision	Intermediate Vision	Near Vision
<input type="checkbox"/> Driving	<input type="checkbox"/> Computer	<input type="checkbox"/> Reading
<input type="checkbox"/> Television	<input type="checkbox"/> Cooking	<input type="checkbox"/> Cell phone
<input type="checkbox"/> Golf	<input type="checkbox"/> Music	<input type="checkbox"/> Crafts / carpentry
Other: _____	Other: _____	Other: _____
Other: _____	Other: _____	Other: _____

- Which of the activities above are the most important to you? _____

Consider your vision since your last visit and answer below.

Today's Date _____

- Select how you feel about the quality of your vision (check one option per range of vision):

Vision Range	Extremely Unsatisfied	Unsatisfied	Somewhat Satisfied	Satisfied	Extremely Satisfied
Distance (i.e., driving, television)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate (i.e., computer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near (i.e., phone, reading)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Comments about your vision: _____
- How often have you experienced the following (check one option per symptom):

Symptoms	Constantly	Often	Sometimes	Rarely	Never
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritated Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuation of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consider your vision since your last visit and answer below.

Today's Date _____

1. Select how you feel about the quality of your vision (check one option per range of vision):

Vision Range	Extremely Unsatisfied	Unsatisfied	Somewhat Satisfied	Satisfied	Extremely Satisfied
Distance (<i>i.e.</i> , driving, television)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate (<i>i.e.</i> , computer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near (<i>i.e.</i> , phone, reading)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Comments about your vision: _____

3. How often have you experienced the following (select one option per symptom):

Symptoms	Constantly	Often	Sometimes	Rarely	Never
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritated Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuation of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consider your vision since your last visit and answer below.

Today's Date _____

1. Select how you feel about the quality of your vision (check one option per range of vision):

Vision Range	Extremely Unsatisfied	Unsatisfied	Somewhat Satisfied	Satisfied	Extremely Satisfied
Distance (<i>i.e.</i> , driving, television)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate (<i>i.e.</i> , computer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near (<i>i.e.</i> , phone, reading)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Comments about your vision: _____

3. How often have you experienced the following (select one option per symptom):

Symptoms	Constantly	Often	Sometimes	Rarely	Never
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritated Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuation of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>