Clinical Vision Evaluation Form

To provide you with the best vision possible, we need to know a little more about you. Please fill in the blanks below regarding your vision needs.

Name_____Date_____

Are you having Vision difficulties at: ☐Work ☐School ☐Play ☐Other _____

Occupation:_____List your favorite hobbies:_____

When spending time?

Outdoors	Any concerns with:	☐Glare	☐Sunlight	☐Safety	☐Health
Driving	Any concerns with:	☐Glare	☐Sunlight	☐Night vision	
Playing sports	Any concerns with:	☐Safety	☐Sunlight	☐Durability	
Computer / TV	Any concerns with:	☐Glare	☐Eyestrain	☐Focus	

Are your eyes sensitive to sunlight?	☐ yes	☐ no
Do you currently have sunglasses?	☐ yes	☐ no
Do you currently wear or interested in contact lenses?	☐ yes	☐ no
If you wear contact lenses do you have glasses?	☐ yes	☐ no

If you currently wear glasses, what would you change about them?

☐ Style ☐More comfort ☐Thinner Lenses ☐Safer ☐Lenses that Change Color
☐Sun protection ☐Less Glare ☐More durable ☐Invisible Bifocal

For Doctors Use Only

Your Vision Treatment Plan:

1. Primary Glasses
_____
_____
_____

2. Sunglasses
_____
_____
_____

3. Computer Glasses
_____
_____
_____

4. Reading Glasses
_____
_____
_____

5. Sports Glasses
_____
_____
_____

Specialty Glasses / Contact lenses
_____
_____
_____