Atlantic Eye
CONSULTANTS

PATIENT OPTICAL INFORMATION

Do you wear eyeglasses? ☐ Yes ☐ No

Do you wear prescription sunglasses? ☐ Yes ☐ No

Please specify how many pairs you own: 1 2 3 4 5 6+

Please circle what you use each pair for below: (check all that apply)

Pair 1	Pair 2	Pair 3	Pair 4	Pair 5	Pair 6	Other
☐ Reading	☐ Reading	☐ Reading	☐ Reading	☐ Reading	☐ Reading	☐ Reading
☐ Distance	☐ Distance	☐ Distance	☐ Distance	☐ Distance	☐ Distance	☐ Distance
☐ Computer	☐ Computer	☐ Computer	☐ Computer	☐ Computer	☐ Computer	☐ Computer
☐ Single Vision	☐ Single Vision	☐ Single Vision	☐ Single Vision	☐ Single Vision	☐ Single Vision	☐ Single Vision
☐ Bifocal	☐ Bifocal	☐ Bifocal	☐ Bifocal	☐ Bifocal	☐ Bifocal	☐ Bifocal
☐ Trifocal	☐ Trifocal	☐ Trifocal	☐ Trifocal	☐ Trifocal	☐ Trifocal	☐ Trifocal
☐ Progressive	☐ Progressive	☐ Progressive	☐ Progressive	☐ Progressive	☐ Progressive	☐ Progressive

Do you have difficulty driving at night due to glare from car headlights and street lamps? ☐ Yes ☐ No

Do you use a computer for more than 30 minutes at a time? ☐ Yes ☐ No If Yes, How long? _____ hours a day

How would you like to improve your current eyewear? Please check all that apply.

☐ Weight ☐ Shape ☐ Frame Color ☐ Polarized lenses ☐ Other _____

☐ Thickness ☐ Fit / Comfort ☐ Glare-free lenses ☐ Computer Lenses ☐ Other _____

☐ Durability ☐ Style ☐ Transition lenses ☐ Scratch Resistance ☐ Other _____

How do you use your eyes for daily or leisure activities? Please check all that apply.

☐ Computer ☐ Watching Television ☐ Golf ☐ Reading ☐ Other _____

☐ Needlework ☐ Playing Sports ☐ Swimming ☐ Piano ☐ Other _____

☐ Hunting ☐ Fishing ☐ Driving ☐ Electrical work ☐ Other _____

PATIENT CONTACT LENS INFORMATION

How do you wear your contacts? ☐ Daily (Remove at night) ☐ Continuous Wear (Sleep while wearing: For _____ Days.)

What is your Contact Lens Brand? _____ Base Curve: _____ Diameter: _____

Prescription Right Eye: _____ Prescription Left Eye: _____

Do you wear: ☐ Sphere ☐ Toric ☐ Multifocal ☐ Multifocal Toric ☐ Monovision ☐ Unknown

Are your contacts comfortable at the end of the day? ☐ Yes ☐ No

Are your contacts comfortable at the end of the wear cycle? (2 weeks / 1 month) ☐ Yes ☐ No

How often do you dispose of your lenses? ☐ 2 weeks ☐ 1 month ☐ Other _____

What brand of solution do you use? _____