

SUNRISE EYE ASSOCIATES

Dr. Jeffrey Gold Dr. Joe Gurwood
225 Bustleton Pike, Feasterville, Pa 19053
215-355-1300

Your Lifestyle

Your answers to these questions will guide us in recommending the best products to meet your individual eyewear needs.

Name _____ Date _____

How long have you been wearing contacts? _____ glasses? _____

What problems, (if any), do you have at present or have had in the past? ___None
___Dryness ___Irritation ___Less than desired comfortable wearing time
___Distance blur ___Trouble reading

How old are your current eyeglasses? _____

Are you planning to get new contacts or glasses today? _____

Do you wear prescription sunglasses? _____ Non-prescription suns? _____

Do you have sunglasses to wear over your contact lenses? _____

When do you wear glasses or contacts?	Glasses	Sunglasses	Contacts
All the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For reading/working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For sports and recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

What is your occupation? _____

List any special visual requirements of your job(s): _____

Which of the following do you do regularly?

- | | |
|--|--|
| <input type="checkbox"/> Night driving | <input type="checkbox"/> Work outdoors |
| <input type="checkbox"/> Commute 20+ minutes by car | <input type="checkbox"/> Work with small objects |
| <input type="checkbox"/> Work under fluorescent light | <input type="checkbox"/> Read for long periods |
| <input type="checkbox"/> Work on a computer | <input type="checkbox"/> Travel on airplanes |
| <input type="checkbox"/> Watch television 3+ hours per day | <input type="checkbox"/> Frequently alternate between indoors and outdoors |
| <input type="checkbox"/> Work at a desk | <input type="checkbox"/> Other _____ |

List all sports and hobbies that you participate in _____

What do you like about your current glasses? _____

What problems, if any, have you had with eyeglasses or contact lenses in the past?

What features will be important in choosing your new glasses?

- | | | |
|---|---|-----------------------------|
| <input type="checkbox"/> Image | <input type="checkbox"/> Weight | ___Glare Free night driving |
| <input type="checkbox"/> Frame Material | <input type="checkbox"/> Lens type | ___Glare Free sunglasses |
| <input type="checkbox"/> Fit | <input type="checkbox"/> Lens thickness | |
| <input type="checkbox"/> Durability | <input type="checkbox"/> Lens color | |