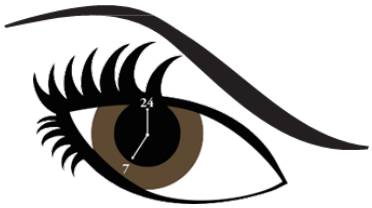

24/7 Vision & EYE CARE
"Clear Sight All Day, Everyday"

Name:_____

Occupation (Job):_____

This questionnaire is designed to assist your eye care Professional in helping you select the perfect Lenses, frames, contacts, and/or refractive procedure, to suit your visual needs and lifestyle. Please take a few minutes to answer the following questions.

1. Which of the following visual demands do you encounter on a regular basis?

   [] Fluorescent Lighting [] Sun Light [] Other _____
   [] Computer Work [] Reading
   [] Potential Eye Hazards [] Close-Up Work

2. Which of the following hobbies or activities do you participate in?

   [] Auto Repair [] Golf [] Reading
   [] Biking [] Home Repair [] Sewing/Arts/Crafts
   [] Boating [] Hunting [] Snow Sports
   [] Bookkeeping [] Jogging/Running [] Water Sports
   [] Competitive Sports [] Landscaping [] Welding
   [] Computer [] Musical Instrument [] Other_____
   [] Driving [] Painting
   [] Exercise [] Pilot
   [] Fishing [] Racketball/Tennis

3. Do your eyes seem bothered by glare from any of the following situations?

   [] Car Headlights [] Computer Monitor [] Fluorescent Lights
   [] Haze [] Night Driving [] Street Lights
   [] Sunshine [] Traffic Lights [] Other_____

4. If you wear contacts, do you have?
   (Check all that apply)
   [] Current pair of prescription glasses [] Dry Eyes
   [] Current pair of prescription sunglasses [] Decreased contact lens wear
   [] Non-prescription over the counter sunglasses [] Other_____

5. What do you like Best about your current glasses or contacts?
   _____
   _____

6. What don't you like about your current glasses or contacts?
   _____
   _____

7. Which of the following do you wear?
   (Check all that apply)
   [] Prescription Sunglasses [] Transition Adjustable Lenses
   [] Computer Lenses [] Non-Glare Lenses
   [] Safety Eyewear [] Bifocals