Jeffrey V. Winston, M.D.
Dr. Louie O.D. • Dr. Luu O.D. • Dr. Ly O.D.

Winston Eye Care

Complete Eye Care – Cataract Surgery to Contact Lenses

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Optical Services

Vision Needs Assessment

Please answer YES or NO to the following statements:

I currently wear glasses.	YES	NO
Have you ever considered an alternative to glasses (contact lenses, Lasik)?	YES	NO
I have a second pair of glasses in case of emergency.	YES	NO
I use a computer.	YES	NO
My glasses seem to scratch easily.	YES	NO
I wear sunglasses.	YES	NO
My eyes sometimes feel tired, especially at the end of the day.	YES	NO
The sun bothers my eyes when I go outside.	YES	NO
I am sensitive to the weight of my glasses on my face.	YES	NO
Have you ever worn contact lenses?	YES	NO

If you stopped wearing your contacts lenses, why? _____

I am sensitive to glare indoors and/or car headlights at night. YES NO

What activities do you enjoy? (reading, watching TV, sports, music etc…)

_____ _____

_____ _____

Do you have any questions or concerns you'd like to discuss with your doctor today?

_____

_____

Thank you! Your input helps us evaluate and recommend the right tools to give you the best vision possible!

Name_____ **Account #**_____