



# Patient Questionnaire

## Nearvision CK

Name \_\_\_\_\_

Date \_\_\_\_\_

Yes	No	Unsure	<i>Motivation Questions</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My main visual problem is poor "near vision" (reading, computer, cell phone, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have great distance vision without glasses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My goal is to become less dependent on reading glasses so I can leave the house without them

Yes	No	Unsure	<i>Targeting Questions</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I now have significant problems with seeing in the distance.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am anticipating that CK will improve my night vision.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am not willing to compromise any distance vision to gain better near vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I expect my reading vision after CK to be just as good as with my best reading glasses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I expect that after CK, there will be no fluctuation in my vision, and my eyes will begin to work together almost immediately
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I expect that after CK I will be able to read extremely fine print, such as stock tables, without reading glasses.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I expect the effects of CK to be permanent.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have changed my prescription more than twice in the last two years.

What type of work do you do? \_\_\_\_\_

How many hours per day do you spend on the computer? \_\_\_\_\_

How many hours per day do you spend reading, either for business or for pleasure? \_\_\_\_\_

Describe any vision issues that occur when driving? \_\_\_\_\_

Other: \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_