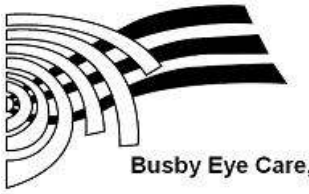

Thank you for choosing Busby Eye Care
for your sports vision needs!
Please fill out this short questionnaire
so that we can help you reach your
full potential as an athlete.

Patient Name:

Age:

Sport(s):

- ☐ Baseball
- ☐ Softball
- ☐ Basketball
- ☐ Hockey
- ☐ Gymnastics
- ☐ Football
- ☐ Karate/Martial Arts
- ☐ Volleyball
- ☐ Soccer
- ☐ Track
- ☐ Tennis
- ☐ Swimming
- ☐ Wrestling
- ☐ Golf
- ☐ Other _____

Competition Level: (record highest level achieved)

- ☐ Grade School
- ☐ Junior High
- ☐ High School
- ☐ Junior College
- ☐ College NCAA Division 2/3
- ☐ College NCAA Division 1
- ☐ Professional (minor league)
- ☐ Professional (major league)
- ☐ Recreational

Rx History:

Date of your last eye exam _____

Do you wear corrective lenses ____ Yes ____ No

If yes, do you wear them for sports ____ Yes ____ No

Describe your current glasses

- ☐ None
- ☐ ASTM f803 Approved Eyewear (prescriptive)
- ☐ Plano Polycarbonate Shield
- ☐ Standard Spectacle

Do you wear contact lenses ____ Yes ____ No

If yes, do you wear them for sports ____ Yes ____ No

Describe your current contact lenses

- ☐ None
- ☐ Soft Sphere Daily Wear
- ☐ Soft Sphere Extended Wear
- ☐ Soft Disposables
- ☐ Soft Toric
- ☐ Rigid Gas Permeable

Ocular Symptoms

Have you ever experienced or have you been told you have any of the following symptoms:

- ☐ Difficulty Seeing
- ☐ Reduced Peripheral Vision
- ☐ Sensitivity to Lights
- ☐ Reduced Performance as Stress Builds
- ☐ Lack of Consistency of Play
- ☐ Headaches
- ☐ Easily Distracted from Visual Target
- ☐ Poor Depth Perception
- ☐ Difficulty Following Moving Objects
- ☐ Blurred Vision After Close Work

Medical History

Describe your current medical health

_____

_____

_____

_____

List any medications you are currently taking

_____