

Great Pair Eyewear



CUSTOMER INFORMATION

Today's date:			
Last name:		First:	
Street address:		Birthday:	
P.O. Box:	City:	State:	ZIP Code:
<input type="checkbox"/> Facebook	<input type="checkbox"/> Instagram	<input type="checkbox"/> Radio	<input type="checkbox"/> Billboard
		<input type="checkbox"/> Movie Theatre	<input type="checkbox"/> Friend/Family
<input type="checkbox"/> Other:			
HOW WE CAN CONTACT YOU			
Please specify, with a star, which of these you would like us to use to contact you.			
Home Phone		Facebook	
Cell Phone: text or call		Instagram	
Email		Other	
QUESTIONNAIRE			
Is this your first pair of glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, how many do you currently use?	
How many hours per day do you wear your glasses?		Are you sensitive to light?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your favorite thing about your old glasses?		What is your least favorite thing about your old glasses?	
Are you in and out of buildings all day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a useable pair of backup glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
At which distance do you usually use your glasses?	<input type="checkbox"/> Far away	<input type="checkbox"/> At arm's length	<input type="checkbox"/> Up close <input type="checkbox"/> Other:
If any, what brands do you like to wear?			
What are your favorite outdoor activities?	<input type="checkbox"/> Contact Sports	<input type="checkbox"/> Gardening	<input type="checkbox"/> Fishing <input type="checkbox"/> Other:
What are your favorite indoor activities?	<input type="checkbox"/> Watching Television	<input type="checkbox"/> Reading	<input type="checkbox"/> Sewing / Knitting <input type="checkbox"/> Computer / Video Gaming <input type="checkbox"/> Other:
How much time do you spend driving at night?	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> A lot <input type="checkbox"/> Not at all
How much time do you spend each day at the computer?	<input type="checkbox"/> Less than an hour	<input type="checkbox"/> A few hours	<input type="checkbox"/> All day <input type="checkbox"/> Other:
How long are you typically on electronic devices per day?	<input type="checkbox"/> Less than an hour	<input type="checkbox"/> A few hours	<input type="checkbox"/> All day <input type="checkbox"/> Other:
Is there anything else that you would like us to know about your eye needs?			
The information provided is to help us better understand your vision care needs. The contact information is only so we can contact you when the job is completed. We will not post or use your information unless told to do so.			
Customer signature			Date