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

________________________________________________________________________