Patient Lifestyle Questionnaire

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us to better understand your vision care needs.

Do you use prescription glasses? _____ Yes _____ No

If you wear single vision glasses are they used for: (Please check one)

____ Distance ____ Reading ____ Switch between a pair for distance and a pair for near

Do you wear Contact Lenses? If so, what style? _____

Are you interested in wearing contact lenses? _____ Yes _____ No

Vision problems can sometimes interfere with your ability to read and learn so please check all that apply to you so we can better understand your vision needs.

Do you:

- ☐ Notice that your eyes hurt or feel tired after close work
- ☐ Experience headaches after intense visual activities such as reading or computer work
- ☐ Notice that vision blurs at a distance when looking up from near work
- ☐ Have a short attention span when working on reading or other activities up close
- ☐ Notice that print seems to move or go in and out of focus when reading
- ☐ Skip lines or lose your place while reading or copying
- ☐ Skip, substitute, or reread words while reading or copying
- ☐ Reverse letters, numbers or words
- ☐ Use a finger or marker to keep place while reading or writing
- ☐ Read very slowly
- ☐ Experience poor reading comprehension or difficulty remembering what you have read
- ☐ Hold your head very close (within 7-8 inches) to your reading and/or writing material
- ☐ Squint, close or cover one eye while reading
- ☐ Tilt your head in an unusual posture when reading or writing
- ☐ Make errors when copying
- ☐ Feel tired while reading
- ☐ Experience an eye that turns in or out
- ☐ Confuse right and left directions

Do you participate in any sports or recreational activities? Yes No

If yes, what? _____

Patient Name: _____