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.

CURRENT STATUS:

How many pairs of prescription glasses do you currently use? ______________

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

____ For distance only    ____ For reading only    ____ I switch between a pair for distance and a pair for near

Do you wear Bifocals? _____ Trifocals? _____ Progressive (Noline)? _____

Do you use Over the Counter Readers? ______ Which power? ______________

Are you interested in or have you worn lenses that darken in sunlight? ______

Do you have sunglasses? ______ Are they polarized? ______

Do you wear Contact Lenses? If so, what style? Disposable? _____ Extended Wear? ______

Gas Permeable? ______ Bifocal? _______ Unsure _____________

Are you interested in wearing contact lenses? __________

Are you bothered by bright light or reflection? ______

Are there times you would not like to wear glasses/contacts? ______ Are you interested in Lasik surgery? ______

OCCUPATION:

At work, do you read small print? ________ Do you perform fine or up-close work? ______

Are you outdoors all or part of the time? ______

How much time do you spend each day on a computer? (Please circle one)

None  1-2 hrs.  3-6 hrs.  More

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

If yes, what kind? (Please check all that apply)

____ Golfing  ____ Gardening  ____ Skiing/Snow Sports  ____ Hiking  ____ Fishing

____ Jogging/Walking/Aerobics  ____ Motorcycle  ____ Boating/Water Sports

____ Biking/Cycling  ____ Team Sports  ____ Other (Please specify) ______________________________

What are your indoor hobbies?

____ Reading  ____ Arts/Crafts  ____ Sewing/Knitting  ____ Other (Please Specify) __________________

Are you aware of the serious eye conditions that can develop from over exposure to UV rays? Y/N

Patient Name: __________________________________________