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: _____