

Lifestyle Questionnaire

Name: _____

Date: _____

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle.

- Do you wear glasses now? No Yes If Yes: All the time / Sometimes
- How important is it for you to read or use computer without glasses?
Very Important / Important / Not Important
- How many hours per day do you: Read: _____ Use the Computer: _____
- Where do you hold book when reading? Close to face / Chest level / In your lap
- How do you *feel* about wearing glasses? _____
- If it were possible to go without glasses for most of the time, would you like that? No Yes
- Do you drive at night? No Yes If Yes: Occasionally / Nightly / Profession (truck, cab)

Check the following activities you do on a regular basis:

- | | | | |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> Read newspaper, books | <input type="checkbox"/> Read medicine bottles | <input type="checkbox"/> Needlepoint | <input type="checkbox"/> Shop |
| <input type="checkbox"/> Drive daytime | <input type="checkbox"/> Hunt or Fish | <input type="checkbox"/> Paint / Artist | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Drive nighttime | <input type="checkbox"/> Paperwork / Writing | <input type="checkbox"/> Tennis | <input type="checkbox"/> Cook |
| <input type="checkbox"/> Musician | <input type="checkbox"/> Play Cards / Dominos | <input type="checkbox"/> Bicycle | <input type="checkbox"/> Computer |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Photography | <input type="checkbox"/> Spectator Sports | <input type="checkbox"/> Theatre |
| <input type="checkbox"/> Restaurant | <input type="checkbox"/> Other, please specify: _____ | | |

Underline the above activities that you would like to do without glasses if possible.

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

Cosmetic Issues of Interest (please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> BOTOX® Cosmetic | <input type="checkbox"/> Antioxidants for the skin | <input type="checkbox"/> Dermal Fillers-Collagen or Hyaluronic Acid |
| <input type="checkbox"/> Physician Strength Skin Care Products | <input type="checkbox"/> Lip Enhancement | (Juvederm, Restylane) |
| <input type="checkbox"/> Facial wrinkles | <input type="checkbox"/> Restoring volume to face | <input type="checkbox"/> Forehead wrinkles |
| <input type="checkbox"/> Frown lines between the eyes, known as "11's" | <input type="checkbox"/> Crows feet | <input type="checkbox"/> Baggy Eyelids |
| <input type="checkbox"/> Other, please specify: _____ | <input type="checkbox"/> Lid Heaviness | <input type="checkbox"/> Dark Circles Under Eyes |
| | <input type="checkbox"/> Thin Eye Lashes | |

When looking at my face in the mirror, I believe I look younger, the same, or older than my true age?

Younger Than		True Age		Older Than
1	2	3	4	5

Have you previously received any treatments for facial wrinkles? Yes No
If so, which treatment(s)? _____
Approximate Dates? _____

How satisfied were you with your results? Very Satisfied / Somewhat Satisfied / Unsatisfied

Patient's Signature: _____

Tech Initials: _____