LIFESTYLE QUESTIONNAIRE

PATIENT 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 information will assist us in recommending the best options for your eyes and your personal lifestyle.

Do you wear glasses? ❑ Yes ❑ No **If Yes** ❑ All the time ❑ Sometimes

How important is it for you to read or use the computer without glasses?
❑ Very Important ❑ Important ❑ Not Important

How many hours per day do you: Read _____ Use the computer _____

Where do you hold your 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, would you like that? ❑ Yes ❑ No

Do you drive at night? ❑ Yes ❑ No
If yes ❑ Occasionally ❑ Nightly Professionally (truck/cab) ❑ Yes ❑ No

Please check the following activities you do on a regular basis:

❑ Read Newspapers, Books	❑ Hunt or Fish	❑ Needlepoint
❑ Drive daytime	❑ Photography	❑ Tennis
❑ Paperwork/Writing	❑ Paint/Artist	❑ Golf
❑ Cell Phone	❑ Read Medicine Bottles	❑ Musician
❑ Computer/Paperwork	Other_____	

PATIENT SIGNATURE _____ DATE _____

TECH INITIALS _____

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