EYE CENTER OF TEXAS
Leaders in Eye Care

LIFESTYLE QUESTIONNAIRE

PATIENT'S 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? ❑ 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 hour 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 Newspaper, books	❑ Read Medicine bottles	❑ Needlepoint	❑ Shop
❑ Drive daytime	❑ Hunt or Fish	❑ Paint/Artist	❑ Golf
❑ Drive nighttime	❑ Paperwork/Writing	❑ Tennis	❑ Cook
❑ Musician	❑ Play Cards / Dominos	❑ Bicycle	❑ Computer
❑ Cell Phone	❑ Photography	❑ Spectator Sports	❑ Theatre
❑ Restaurant	❑ Other, please specify _____		

<u>Underline</u> 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):

- ❑ BOTOX® Cosmetic
- ❑ Physician Strength Skin Care Products
- ❑ Fine lines & wrinkles
- ❑ Frown lines between the eyes, known as "11's"
- ❑ Other, please specify
- ❑ Antioxidants for the skin
- ❑ Lip Enhancement
- ❑ Restoring volume to face
- ❑ Crows feet
- ❑ Lid Heaviness
- ❑ Thin Eye Lashes
- ❑ Dermal Fillers-Collagen or Hyaluronic Acid (Juvederm, Restylane)
- ❑ Age Spots / Skin Tone
- ❑ Baggy Eyelids
- ❑ Dark Circles Under Eyes

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)? _____

If so, which treatment(s)? _____

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

PATIENT'S SIGNATURE _____ TECH INITIALS _____