Lifestyle Questionnaire

This questionnaire is designed to assist you and our staff in helping select the best lenses, frames, and/or contact lenses to suit your visual needs and lifestyle. Please take a few moments to answer the following questions or work with our staff to answer them together

Patient Name: _____ Date / /

Occupation: _____ Place of Work _____

Do you spend most of your time indoors or outdoors? _____

Circle the following visual demands that you encounter on a regular basis:

Board work Computer work Reading Close-up work

Natural lighting Artificial lighting Potential eye hazards

Circle the following hobbies or activities that you participate in:

Auto repair

Biking

Boating/water sports

Bowling

Competitive sports-type? _____

Cooking

Drawing/painting

Driving

Exercise/running

Fishing

Golf

Hunting/shooting

Home repairs

Landscape/gardening

Musical instrument

Phone/Ipod/Texting

Pilot

Racquetball

Sewing/arts/crafts

Snow sports

Spectator sports

Tennis

Watching TV

Welding

Woodwork

Other? _____

Do your eyes seem bothered by glare from any of these situations?

Headlights	Night driving	Haze	Traffic lights
Computer monitor	Fluorescent lights	Sunshine	

How much time do you spend each day at a computer? _____

Are you experiencing any of the following symptoms while at your computer? Please circle.

Headaches	Sore or tired eyes	Blurred near vision
Glare or light sensitivity	Dry or watery eyes	Blurred distance vision
Burning, itching or red eyes	Double vision	
Focusing problems, distance to near and back		

Do you wear glasses while working at the computer? _____

Do you wear contact lenses? _____ For social use? _____ Work? _____

Do you have a back-up pair of prescription glasses? _____

Do you have nonprescription sunglasses? _____

What do you like about your current glasses or contact lenses (color, style, fit, etc...)? _____

_____

_____

What do you not like about them(weight, thickness, glare, etc...)? _____

_____

_____