The eye Center, P.A.

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LIFESTYLE VISION QUESTIONNAIRE

Patient Name:	Today's 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 option(s) for your eyes and your personal lifestyle vision.

Do you wear glasses? ☐ Yes ☐ No

If yes, please specify: ☐all the time ☐sometimes ☐only for distance ☐only for reading ☐only for computer

How important is it for you to see, read or use a computer without glasses?

☐ very important ☐ important ☐ somewhat important ☐ not important

If it were possible to go without glasses the majority of the time, would you like that? ☐ Yes ☐ No

How many hours per day do you: read ____ use a computer ____

Do you drive at night? ☐ No ☐ Yes: ☐ socially ☐ occasionally ☐ profession (truck, cab, etc.)

Check the following activities you do on a regular basis:

☐ Read: newspaper, books, etc.	☐ Wall Street Journal	☐ Drive: daytime	☐ Drive: nighttime
☐ Read: medicine bottles	☐ Shop	☐ Golf	☐ Tennis
☐ Needlepoint	☐ Hunt or Fish	☐ Paint / Artist	☐ Cook
☐ Musician	☐ Play Cards / Dominoes	☐ Bicycling, Roller Blades, etc.	☐ Photography
☐ Spectator Sports	☐ Movie Theatre	☐ Dine in Restaurant	☐ Cell Phone
☐ Other: *please specify*			

***Underline* the above activities that you would like to see WITHOUT glasses if possible.**

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

Please place an "X" on the scale below that best represents your personality:

Easy Going --- Perfectionist

PATIENT'S SIGNATURE:	