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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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Read: newspaper, books, etc. | <input type="checkbox"/> Wall Street Journal | <input type="checkbox"/> Drive: daytime | <input type="checkbox"/> Drive: nighttime |
| <input type="checkbox"/> Read: medicine bottles | <input type="checkbox"/> Shop | <input type="checkbox"/> Golf | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Needlepoint | <input type="checkbox"/> Hunt or Fish | <input type="checkbox"/> Paint / Artist | <input type="checkbox"/> Cook |
| <input type="checkbox"/> Musician | <input type="checkbox"/> Play Cards / Dominoes | <input type="checkbox"/> Bicycling, Roller Blades, etc. | <input type="checkbox"/> Photography |
| <input type="checkbox"/> Spectator Sports | <input type="checkbox"/> Movie Theatre | <input type="checkbox"/> Dine in Restaurant | <input type="checkbox"/> Cell Phone |
| <input type="checkbox"/> Other: <i>please specify</i> | | | |

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: