Lifestyle Questionnaire

Patients Name: ______________________________ Date of visit: ____________________
Occupation: ________________________

This questionnaire is designed to assist your eyecare professional in helping you select the perfect lenses, frames, or contacts to suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

1. **Which of the following visual demands do you encounter on a regular basis?**
   (Please Check all that apply)

   ___ Artificial Lighting ___ Computer Work ___ Potential eye hazards
   ___ ClassroomWork ___ Natural Lighting ___ Reading
   ___ Close-up work ___ Paperwork ___ Other

2. **Which of the following hobbies or activities do you participate in?**

   ___ Auto repair ___ Biking ___ Boating/Watersports
   ___ Bookkeeping ___ Bowling ___ Competitive Sports
   ___ Computer ___ Drawing ___ Driving
   ___ Fishing ___ Golf ___ Hunting
   ___ Jogging/running ___ Gardening ___ Music
   ___ Painting ___ Pilot ___ Reading
   ___ Sewing/arts& crafts ___ Snow sports ___ Tennis
   ___ Watching TV ___ Welding ___ Woodwork
   ___Other ____

3. **Do your eyes seem bothered by glare from any of the following situations?**

   ___ Car headlights ___ CPU Screen ___ Fluorescent Lights
   ___ Haze ___ Night Driving ___ Sunshine
   Other: ____

4. **If you wear contacts, do you have the following?**

   ___ Current pair of prescription glasses
   ___ Good pair of sunglasses

5. **What do you like about your current pair of glasses or contacts?**

   ____
   ____
   ____

6. **What don't you like about your current pair of glasses or contacts?**

   ____
   ____
   ____