

Lifestyle Questionnaire

Patient Name: _____ Date of Visit: _____

Occupation: _____

This questionnaire is designed to assist your eyecare professional in helping you select the perfect lenses, frames and/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?

(Check all that apply)

- | | | |
|---|--|---|
| <input type="radio"/> Artificial lighting | <input type="radio"/> Computer work | <input type="radio"/> Potential eye hazards |
| <input type="radio"/> Board work | <input type="radio"/> Natural lighting | <input type="radio"/> Reading |
| <input type="radio"/> Close-up work | <input type="radio"/> Paperwork | <input type="radio"/> Other |

2. Which of the following hobbies or activities do you participate in? *(Check all that apply)*

- | | | |
|--|---|--|
| <input type="radio"/> Auto repair | <input type="radio"/> Fishing | <input type="radio"/> Reading |
| <input type="radio"/> Biking | <input type="radio"/> Golf | <input type="radio"/> Sewing/arts/crafts |
| <input type="radio"/> Boating/water sports | <input type="radio"/> Home repairs | <input type="radio"/> Snow sports |
| <input type="radio"/> Bookkeeping | <input type="radio"/> Hunting/shooting | <input type="radio"/> Spectator sports |
| <input type="radio"/> Bowling | <input type="radio"/> Jogging/running | <input type="radio"/> Tennis |
| <input type="radio"/> Competitive sports | <input type="radio"/> Landscaping/gardening | <input type="radio"/> Watching TV |
| <input type="radio"/> Computer | <input type="radio"/> Musical instrument | <input type="radio"/> Welding |
| <input type="radio"/> Drawing | <input type="radio"/> Painting | <input type="radio"/> Woodwork |
| <input type="radio"/> Driving | <input type="radio"/> Pilot | <input type="radio"/> Other: |
| <input type="radio"/> Exercise | <input type="radio"/> Racquetball | |

Lifestyle Questionnaire continued

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

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="radio"/> Car headlights | <input type="radio"/> Haze | <input type="radio"/> Traffic lights |
| <input type="radio"/> Computer monitor | <input type="radio"/> Night Driving | <input type="radio"/> Other: |
| <input type="radio"/> Fluorescent lights | <input type="radio"/> Sunshine | |

4. If you wear contacts, do you have: (Check all that apply)

- Current pair of prescription glasses
- Sunglasses (purchased at a boutique, department / optical store)
- Other:

5. Do you have any metal or silicon allergies?

- Yes No

6. What do you like about your current glasses or contacts (color, style, fit, etc.)?

7. What don't you like about your current glasses or contacts (weight, thickness, glare, etc.)?
