Lifestyle Questionnaire

Patient Name:_____ Date of Visit:_____
Occupation:_____

This questionnaire is designed to assist your eyecare professional in helping you select the perfect lenses, frame 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*)

O Artificial Lighting
O Board Work
O Close Up Work
O Computer Work
O Natural Lighting
O Paperwork
O Potential Eye Hazards
O Reading
O Other

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

O Auto Repair
O Biking
O Boating, Aquatics
O Bookkeeping
O Bowling
O Competitive Sports
O Computer
O Drawing
O Driving
O Exercise
O Fishing
O Golf
O Home Repairs
O Hunting/Shooting
O Jogging/Running
O Landscaping/Gardening
O Musical Instrument
O Painting
O Pilot
O Racquetball
O Reading
O Sewing/Arts/Crafts
O Snow Sports
O Spectator Sports
O Tennis
O Watching T.V
O Welding
O Woodwork
O Other:

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

O Car Headlights
O Computer Monitor
O Fluorescent Lights
O Haze
O Night Driving
O Sunshine
O Traffic Lights
O Other:

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

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

5: Do you have any metal or silicone allergies?

O Yes O 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.*)?

_____

_____

_____

8: Reason(s) for today's visit:

_____

_____

9: Questions for Dr. Barnes:

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