

LIFESTYLE VISION QUESTIONNAIRE

Name:	Date	
We recognize that your eyes are very important to you. We would like to know how <u>you</u> use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.		
 Do you wear glasses now? □ No If Yes, how often? □ All the time □ Only for dis 		☐ Only for computer
 How important is it for you to see to read or use computer without glasses? □ Very important □ Important □ Somewhat important □ Not important 		
 If it were possible to go without glasses for most of the time, would you like that? □ No □ Yes 		
How many hours per day do you: Read? hrs Use computer? hrs		
Do you drive at night? □ Socially	□ Occasionally □ Often	
CHECK the following activities you do on a regular basis:		
□ Read books	☐ Play Cards / Dominos	□ Drive daytime
☐ Read medicine bottles	□ Paint / Artist	☐ Drive nighttime
□ Needlepoint / Crochet	□ Cook	□ Golf
☐ Dine in Restaurant	□ Musician	☐ Hunt / Fish
☐ Shopping	□ Computer / Tablet	☐ Bicycling, Hiking etc.
□ Photography	□ Cell phone	□ Tennis
□ Other		☐ Spectator Sports
Please circle on the following scale to describe your personality as best you can:		
1 2 3 Easy going	4 5 6 7	8 9 10 Perfectionist