Lifestyle Questionnaire

This questionnaire is to assist your eye care physician in prescribing you the perfect lenses, frames, and/or contacts to best suit your visual needs and lifestyle. Your eyewear is a personal investment in health and comfort, and we would like to get to know you better to help find suitable options for all of your eye care needs.

Please take a few moments to answer the following questions:

Patient Name_____ **Date of Visit** _____

Phone Number_____ **Email:**_____

Address: _____

_____

1. Nature of Visit:

▢ Visual Problem - Specify: _____
▢ First Eye Exam ▢ Diabetic ▢ Physician Referral

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

▢ Computer Work
How many hrs/day?_____
▢ Artificial Lighting
▢ Potential Eye Hazards
▢ Work with Small Objects
▢ Reading
▢ Boardwork
▢ Paperwork
▢ Natural Lighting
▢ Close-Up Work
▢ Other:_____

3. What is your Occupation/Employer:_____

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

▢ Auto Repair
▢ Basketball
▢ Biking
▢ Boating/Water Sports
▢ Bowling
▢ Competitive Sports
▢ Computer
▢ Drawing
▢ Driving
▢ Jogging/Running
▢ Landscaping/Gardening
▢ Musical Instrument
▢ Painting
▢ Pilot
▢ Racquetball
▢ Reading
▢ Sewing/Arts/Crafts
▢ Snow Sports
▢ Spectator Sports
▢ Other:_____
▢ Hunting/Shooting
▢ Watching TV
▢ Welding
▢ Woodwork
▢ Home Repairs
▢ Golf
▢ Tennis
▢ Fishing
▢ Exercise

5. Do your eyes seem bothered by glare from any of the following situations? (Check all that apply)

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

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6. Do you have any metal or silicon allergies? ▢ Yes ▢ No

7. How long have you been wearing Glasses?_____ **Contacts**?_____

8. What percent of time do you wear your Glasses?_____**Contacts**?_____

9. Do you wear prescription sunglasses? ▢ Yes ▢ No

10. Do you wear non-prescription sunglasses? ▢ Yes ▢ No

11. In regards to contact lense use and safety: (Check all that apply)

▢ I have issues with end-of-day dryness or discomfort with my contact lenses
▢ I am interested in enhancing my look with color contact lenses
▢ I sometimes fall asleep in my contact lenses, either napping or at night
▢ I notice my near vision has become blurry, which interferes in my daily activities (using my phone, reading menus, driving, etc).
▢ When I store my contact lenses, I pour new cleaning and disinfecting lens solution into the lens case each time.

12. When do you wear your corrective eyewear?	**Glasses**	**Sunglasses**	**Contacts**
All of the time	▢	▢	▢
For reading/working	▢	▢	▢
For driving	▢	▢	▢
For sports/recreation	▢	▢	▢
Other	▢	▢	▢

13. What do you like most about your current glasses?

_____

_____

14. What features will be important in choosing your new glasses? (Check all that apply)

▢ Look	▢ Frame Material	▢ Fit	▢ Durability	▢ Weight
▢ Brand	▢ Fashion Trends	▢ Lens Type	▢ Lens Thickness	▢ Frame Color
▢ Lens Color	▢ Other:_____			

15. What is your favorite Brand of glasses? _____

Patient Signature: _____ **Date**:_____