Patient Lifestyle Questionnaire

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us to better understand your vision care needs.

What is your professional environment? (Check all that apply.)

____ I work in a professional business office ____ My job requires travel (driving/flying/both).

____ I work from home. ____ I work outside most of the time.

How much time do you spend each day at a computer?

____ 0-1 Hour ____1-3 Hours ____3-5 Hours ____5+ Hours

How much time do you spend driving at night? (hours/minutes)

____

What type of outdoor activities do you participate in? (Check all that apply.)

____ Golfing ____Gardening ____Skiing ____Hiking ____Jogging/Walking ____Boating ____Biking

____Team Sports ____Other (please list) ____

What are your indoor hobbies?

____Reading ____Arts/Crafts ____Sewing/Knitting ____Other

Please list any skin allergies. ____

____

Are you concerned about protecting your eyes from harmful UV rays? ____Yes ____No

What do you currently use for sunwear? ____

What did you like about your last pair of glasses? ____

What would you change? ____

What did you like about your last pair of sunglasses? ____

What would you change? ____

Office Use Only

Patient Name ____

Date of Visit ____

Vision Care Recommendations

Frames ____

Lenses ____

Contacts ____

Sunglasses ____

Other ____