

Ophthalmology – Lifestyle Vision Questionnaire

Patient Name: _____ Date: _____

We recognize that your eyes are very important to you. We would like to know how you 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? Yes _____ No _____
 If Yes All the time _____ Sometimes _____
 Only for distance _____ For reading _____
 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?
 Yes _____ No _____
- How many hours per day do you: Read _____ Use computer _____
- Do you drive at night? Socially _____ Occasionally _____ As profession _____

Check the following activities you do on a regular basis:

- | | | |
|-----------------------|-----------------------|------------------------------|
| Read newspaper, books | Read medicine bottles | Needlepoint |
| Wall Street Journal | Drive daytime | Drive nighttime |
| Shop | Golf | Tennis |
| Hunt or Fish | Paint/Artist | Cook |
| Musician | Play Cards/Dominos | Bicycling, Rollerblades, etc |
| Photography | Spectator Sports | Movie theatre |
| Dine in Restaurant | | |

Underline the above activities that you would like to see without glasses if possible

What occupational, recreational, or other activities do you currently engage in that are not listed above?

Please place an "X" on the following scale to describe your personality as best you can:

Easy going _____ Perfectionist _____

Functional Impairment Survey

1. I am having trouble with my near or reading vision
Yes or No
2. I am having trouble with my distance or driving vision
Yes or No
3. I am having trouble with glare or halos that blur my vision
Yes or No
4. It is my desire to improve my vision and to improve my vision functionality
5. I am having trouble with glare or halos that blur my vision
Yes or No

Signature_____