

Help Us Help You – A Vision Lifestyle Questionnaire

Last Name _____ First _____ Date of Birth _____

Occupation _____ Age _____ Sex Male Female

In order for our doctors and eye care professionals to assist you in making the best possible decisions about your vision and general eye health, please take a moment to complete this brief questionnaire. It is designed to indicate what eye health options might be right for you. *Thank you.*

1. **Do you currently wear eyeglasses?** Yes No
If Yes, for what purpose? _____

2. **Are you interested in reducing your need for glasses?** Yes No

3. **Do you wear contacts?** Yes No
(If yes, check all that apply)

- I have a current pair of prescription eyeglasses
- I have a current pair of prescription sunglasses
- I have non- prescription sunglasses
- I use over the counter reading glasses

4. **If you do not currently wear contacts are you interested in seeing if you are a good candidate?**
 Yes No

5. **Do you spend more than one hour per day in the sun?** Yes No

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

<input type="checkbox"/> Artificial lighting	<input type="checkbox"/> Natural lighting	<input type="checkbox"/> Potential eye hazards
<input type="checkbox"/> Night driving	<input type="checkbox"/> Reading	<input type="checkbox"/> Close-up work
<input type="checkbox"/> Paperwork	<input type="checkbox"/> Computer work	<input type="checkbox"/> Other _____

7. **How many hours per day do you spend on a computer?** _____ **Reading?** _____

8. **Which of the following hobbies or activities do you participate in?** (check all that apply)

<input type="checkbox"/> Fishing	<input type="checkbox"/> Reading	<input type="checkbox"/> Biking
<input type="checkbox"/> Golf	<input type="checkbox"/> Sewing/arts/crafts	<input type="checkbox"/> Boating/Water sports
<input type="checkbox"/> Snow sports	<input type="checkbox"/> Bookkeeping	<input type="checkbox"/> Hunting/shooting
<input type="checkbox"/> Landscaping/gardening	<input type="checkbox"/> Watching TV	<input type="checkbox"/> Computer
<input type="checkbox"/> Musical instrument	<input type="checkbox"/> Welding/woodwork	<input type="checkbox"/> Drawing/painting
<input type="checkbox"/> Other _____		

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

<input type="checkbox"/> Car headlights	<input type="checkbox"/> Haze	<input type="checkbox"/> Sunshine
<input type="checkbox"/> Computer monitor	<input type="checkbox"/> Night driving	<input type="checkbox"/> Traffic lights
<input type="checkbox"/> Fluorescent lights	<input type="checkbox"/> Other _____	

10. **Do you frequently drive at night?** Yes No

11. **How would your friends describe your personality?** Circle one

Easy going 1 ... 2 ... 3 ... 4 ... 5 Perfectionist

Chart # _____

Date: _____