Lifestyle Questionnaire

Patient Name:_____Date of Visit:_____

Occupation:_____

This questionnaire is designed to assist your eyecare professional in helping you select the perfect lenses, frames and/or contacts to suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

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

- ◯ Artificial lighting
- ◯ Board work
- ◯ Close-up work
- ◯ Computer work
- ◯ Natural lighting
- ◯ Paperwork
- ◯ Potential eye hazards
- ◯ Reading
- ◯ Other

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

- ◯ Auto repair
- ◯ Biking
- ◯ Boating/water sports
- ◯ Bookeeping
- ◯ Bowling
- ◯ Competitive sports
- ◯ Computer
- ◯ Drawing
- ◯ Driving
- ◯ Exercise
- ◯ Fishing
- ◯ Golf
- ◯ Home repairs
- ◯ Hunting/shooting
- ◯ Jogging/running
- ◯ Landscaping/gardening
- ◯ Musical instrument
- ◯ Painting
- ◯ Pilot
- ◯ Racquetball
- ◯ Reading
- ◯ Sewing/arts/crafts
- ◯ Snow sports
- ◯ Spectator sports
- ◯ Tennis
- ◯ Watching TV
- ◯ Welding
- ◯ Woodwork
- ◯ Other:

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Lifestyle Questionnaire continued

3. Do your eyes seem bothered by glare from any of the following situations:

- ◯ Car headlights
- ◯ Computer monitor
- ◯ Fluorescent lights
- ◯ Haze
- ◯ Night Driving
- ◯ Sunshine
- ◯ Traffic lights
- ◯ Other:

4. If you wear contacts, do you have: *(Check all that apply)*

- ◯ Current pair of prescription glasses
- ◯ Sunglasses (purchased at a boutique, department / optical store)
- ◯ Other:

5. Do you have any metal or silicon allergies?

- ◯ Yes
- ◯ No

6. What do you like about your current glasses or contacts (color, style, fit, etc.)?

7. What don't you like about your current glasses or contacts (weight, thickness, glare, etc.)?

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