Lifestyle Questionnaire

Patient Name: _____

Date: _____

Please tell us a little bit about yourself so we can create a perfect vision treatment plan for you.

What is your occupation? _____

How may hours per day...

Are you on a computer: ☐ >3 Hours ☐ 3-6 Hours ☐ 6+ Hours

Are you on a smart phone: ☐ >2 Hours ☐ 2-4 Hours ☐ 4+ Hours

Do you watch TV: ☐ >1 Hours ☐ 1-2 Hours ☐ 2+ Hours

Do you drive: ☐ >1 Hours ☐ 1-2 Hours ☐ 2+ Hours

Circle what you do for fun?

Outdoor Leisure:	**Sports:**	**Indoor:**
Fishing, Golf, Hiking, Hunting,	Basketball, Biking, Football,	Crafting, TV, Video, Music,
Skiing, Motorcycle, Walking,	Tennis, Baseball, Racketball,	Reading, Video Gaming, Card
Gardening, Yardwork,	Running, Soccer, Swimming,	Playing, Puzzles, Woodworking,
Birdwatching, Travel	Volleyball	Painting, Shopping

Other: _____

_____

Do you currently wear contacts? Yes No **Are you interested in contacts?** Yes No

Do you have any issues with your current contacts? Yes No

If yes, please explain: _____

_____

Do you have more than one pair of current Rx eyewear? Yes No

If yes, what types of eyewear do you have?

☐ Computer ☐ Sunwear ☐ Sports/Hobby ☐ Everyday ☐ Luxury

Do you have any issues with your current eyewear? If yes, please explain. _____

_____

What is important to you about your eyewear?

☐ Comfort	☐ Current Lens Technology	☐ Thin Lens
☐ Optimized Vision	☐ Eyewear Wardrobe	☐ Melanoma Prevention
☐ Updating Your Look	☐ Glare Reduction	☐ Backup Pair