Lifestyle Vision® Questionnaire

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? ____No If Yes: ____All the time ____Sometimes
  ____Only for far distance ____Only for reading ____Only for the computer

Check the following activities you do on a regular basis:

☐ Read Newspapers/Books	☐ Read Medicine Bottles	☐ Needlepoint/Sew	☐ Participate in Water Sports
☐ Drive – Daytime	☐ Drive – Nighttime	☐ Shop	☐ Use iPhone/Blackberry
☐ Play Tennis	☐ Hunt or Fish	☐ Paint/Draw	☐ Watch Spectator Sports
☐ Play a Musical Instrument	☐ Dine in Restaurants	☐ Bicycle	☐ Play Cards/Dominos
☐ Use the Computer	☐ Golf	☐ Use Cell Phone	☐ Watch Movies in Theatre
☐ Photography	☐ Cook	☐ Paperwork/Writing	

***Underline* the above activities you would like to do *without glasses*, if possible.**

- How important is it for you to read or use the computer without glasses?
  ____Very important ____Important ____Not important
- How many hours per day do you: Read?_____ Use the computer?_____
- Where do you hold your book when reading? ____Close to your face ____Chest level ____In your lap
- How do you feel about wearing glasses?_____
- If it were possible to go without glasses most of the time, would you like that? ____No ____Yes
- Do you drive at night? ___No If Yes: ___Occasionally ___Nightly ____As profession (truck, cab, etc.)
- 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**