



3020 N. Military Trail, Suite #150 – Boca Raton, FL 33431
www.cohenlaser.com info@cohenlaser.com
Phone: 561-981-8400 Fax: 561-981-8460

Vision Lifestyle Questionnaire

Name: _____ DOB: _____ AGE: _____

There are a **variety of options for refractive surgery** that will not only give you clearer vision but may also reduce your dependency on glasses. Please help us better understand what is important to you in order to determine which option is best suited for your lifestyle.

Please circle the following activities that you do on a regular basis and are **important** to your lifestyle:

Distance Vision



Driving—daytime



Watching movies/Going to theater



Driving—nighttime



Viewing scenery/Taking photographs



Golfing/Other sports

Other: _____

Intermediate Vision



Seeing car dashboard



Shopping



Using computer



Playing cards



Using tablet

Other: _____

Near Vision



Reading books/newspapers



Sewing/Needlepointing



Doing crossword puzzles



Applying makeup



Using cell phone

Other: _____

Are you currently having any difficulty with the following scenarios?

Bright daylight

Nighttime streetlights/headlights

Reading

Please place an "X" on each continuum where it best describes how you feel about the following:

Correction of **near** vision:
(eg, reading, use of phone)

I want to wear glasses

I don't want to wear glasses

Correction of **intermediate** vision:
(eg, using tablet/computer)

I want to wear glasses

I don't want to wear glasses

Correction of **distance** vision:
(eg, driving, watching television)

I want to wear glasses

I don't want to wear glasses

Your doctor will discuss the advantages and disadvantages of the various options for refractive surgery. Please indicate level of knowledge and understanding.

Not knowledgeable

Somewhat knowledgeable

Knowledgeable

Which of the following best describes your personality type?

Easygoing

Flexible

Organized/Planner

Perfectionist

Patient Signature: _____