Eye Treatment Center
LIFESTYLE QUESTIONNAIRE

Patient Name: _____**Date of Visit:** _____

Occupation: _____

This questionnaire is designed to assist your eye care 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)

☐ Close-up work ☐ Paperwork ☐ Natural lighting

☐ Computer work ☐ Potential eye hazards ☐ Other:

☐ Board work ☐ Reading

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

☐ Artificial lighting ☐ Exercise ☐ Racquetball

☐ Auto repair ☐ Fishing ☐ Reading

☐ Biking ☐ Golf ☐ Sewing/arts/crafts

☐ Boating/water sports ☐ Home repairs ☐ Snow sports

☐ Bookkeeping ☐ Hunting/shooting ☐ Spectator sports

☐ Bowling ☐ Jogging/running ☐ Tennis

☐ Competitive sports ☐ Garden/Landscape ☐ Watching TV

☐ Computer ☐ Musical instrument ☐ Welding

☐ Drawing ☐ Painting ☐ Woodwork

☐ Driving ☐ Pilot ☐ Other:

3. How much screen time do you have? (Check all that apply and list # hours/day)

☐ Desktop Computer: _____ (hours/day)

☐ Laptop Computer: _____ (hours/day)

☐ Tablet/I-Pad/Kindle/E-reader: _____ (hours/day)

☐ Mobile Phone: _____ (hours/day)

☐ Other (list activity): _____||_____ (hours/day)

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

☐ Car headlights ☐ Haze ☐ Traffic lights

☐ Computer monitor ☐ Night Driving ☐ Other:

☐ Fluorescent lights ☐ Sunshine

5. 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:

6. Do you have any metal or silicone allergies?

☐ Yes ☐ No

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

_____

_____

_____

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

_____

_____

_____