

# Patient Lifestyle Questionnaire

To better help your physician diagnose and treat your visual difficulties, please check the following that apply:



I wear:             Contacts                       Glasses                       No vision correction

It is difficult to (even while wearing my contacts or glasses):

- |  |                                   |   |                                       |
|--|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Read newspaper/books          | <input type="checkbox"/> Watch TV | <input type="checkbox"/> See steps          | <input type="checkbox"/> Drive in the |
| <input type="checkbox"/> Do computer work              | <input type="checkbox"/> Sew      | <input type="checkbox"/> Read traffic signs | <input type="checkbox"/> day          |
| <input type="checkbox"/> Enjoy recreational activities |                                   |   | <input type="checkbox"/> night        |

I currently have problems with:

- |                                    |  |  |                                      |
|------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Glare     | <input type="checkbox"/> Halos around lights | <input type="checkbox"/> Blurred vision    | <input type="checkbox"/> Hazy vision |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seeing in dim light | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Tired eyes  |

I enjoy the following hobbies/activities (ie: golfing, reading, swimming, etc.):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**If you wear glasses or contacts, please answer the following questions:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are you happy with your current glasses or contacts? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Would you like to visit our optical shop?            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you currently have more than one pair of glasses? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| If yes, reason: _____                                |                              |                             |
| Do you use a computer?                               | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| If yes, how many hours average per day? _____        |                              |                             |
| Are you happy with your reading and distance vision? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you interested in contact lenses?                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you raise your eyelids to see better?             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do your eyelids bother you?                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you wear sunglasses?                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Please let us know which of the following services you may be interested in learning more about:**

**Cataract & Refractive Procedures**

- LASIK (Laser Vision Correction)
- Cataract Surgery
- Lens Implants
- Other \_\_\_\_\_

**Eyelid & Facial Cosmetic Procedures**

- Upper/Lower Eyelid Surgery
- Microdermabrasion
- Botox or  Restylane
- Laser Hair Removal

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date