Lifestyle Questionnaire

Dear Patient: This questionnaire was created to assist us in helping you choose the eyewear best suited to your particular needs and lifestyle concerns. Please take a moment to answer all the questions that apply to you. Thank you for taking the time to complete this form.

1. What do you like about your current pair of glasses and or contact lenses?

2. What don't you like about your current pair of glasses and or contact lenses?

3. Your activities: (circle all that apply)

cooking sewing needlepoint/knitting board games soldering/welding painting woodworking electrical
golf skiing/skating/snow boarding snorkling/suba/swim auto repair plumbing use of power tools
painting musical instrument art scrapebook/crafts cards/bingo woodworking fishing boating gardening/landscaping

4. Are you bothered by glare from any of the following? (circle all that apply)

night driving/headlights haze flourscent lights smart phone
sunshine/uv exposure computer screens other tablets

5. Does your work entail unusual visual demands due to any of the following: (circle all that apply)

distance viewing
near viewing
position
outdoor work
indoor work
driving
natural or artifical lighting
abrupt changes in light levels
microscope/ telescope
caustic environent
clean room
other

6. What electronic devices do you use: smart phone, tablet, kindel, video games and how much time on each device. Do your eyes tire after viewing/reading/using these devices?

7. Do you currently use more than one pair of glasses? NO YES (circle all that apply below)

bifocals
trifocals
multifocals
occupational
distance
reading
intermediate
computer
other hobby:
golf
tennis
shooting
hunting
sunglasses
scuba specs
swim goggles
ski goggles
driving
protective eyewear

8. Do you see clearly with the glasses for all the tasks which you need to complete? YES NO
if NO... please explain

9. Do you use a computer? NO YES What is the distance from the screen to your eyes?_____inches? Lap top, distance _____inches
Is the screen positioned to your Right Left Center ? How many hours do you spend at the computer a day?_____

10. Do you currently wear contact lenses? NO YES What type of lens? (soft/disposable/gas permeable/bifocal etc.)
What disinfection system do you use?_____

How many hours a day do you wear your contact lenses?_____Disinfection System:_____

Please list all family members living at home:

Name	Last eye exam	Date of birth

Thank You

Revised Dr. Groo0314