

# PATIENT LIFESTYLE QUESTIONNAIRE

## EYEWEAR

- 1) Do your glasses sometimes irritate your face?  Yes  No
- 2) If you could, would you prefer not to wear glasses?  Yes  No
- 3) Are you satisfied with the way your glasses look and feel?  Yes  No
- 4) Are you satisfied with the vision and comfort your glasses provide?  Yes  No
- 5) If your glasses were lost or destroyed, could you function well at work, at home and with hobbies?  Yes  No
- 6) Do you wear sunglasses?  Yes  No
- 7) If you wear bifocals, are you bothered by the lines or do you sometimes tilt your head to see?  Yes  No

## CONTACT LENSES

- 1) How often do you wear your contact lenses? \_\_\_\_\_
- 2) What cleaning solutions do you use? \_\_\_\_\_
- 3) Do you experience dry or itchy eyes or dry contacts?  Yes  No
- 4) Are you interested in contacts that change the color of your eyes?  Yes  No
- 5) Are you interested in the latest contact lens designs?  Yes  No

## OCCUPATION

What is your occupation? \_\_\_\_\_

### Do you:

- Work at a computer?  Yes  No
- Work outdoors?  Yes  No
- Work in a hazardous environment, such as manufacturing?  Yes  No

## LIFESTYLE

What hobbies do you enjoy? (e.g. reading, gardening, woodworking, sewing) \_\_\_\_\_

What sports activities do you enjoy? (e.g. water sports, snow sports, fishing, hunting, walking/running) \_\_\_\_\_

How many hours a day do you spend driving? \_\_\_\_\_

### Do you:

- Spend time in areas with low lighting?  Yes  No
- Drive frequently at dawn, dusk or night?  Yes  No
- Drive frequently with the sun in your eyes?  Yes  No

## FAMILY

Do you have children?  Yes  No

If any family members wear eyewear, please indicate so below.

Family member's relationship	Wear eyewear	
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## COMMENTS

Anything else you'd like to share with us? \_\_\_\_\_

\_\_\_\_\_