Lifestyle Questionnaire

Name: ________________________________ Date: ____________________

We would like to know how you use your eyes on a daily basis. Along with your eye exam, this information will assist us in recommending the best options for your eyes and your lifestyle.

- ❖ Do you currently wear glasses? ☐ Yes – All the time ☐ Yes – sometimes ☐ No
- ❖ Would you like to be able to read or use the computer without glasses? ☐ Yes ☐ Don't mind wearing glasses
- ❖ How many hours a day do you…………… Read?_______ Use a computer? _______
- ❖ Would it be okay if you had to wear glasses once in a while, especially for small print? ☐ Yes ☐ No
- ❖ Do you drive at night? ☐ No If Yes: ☐ Occasionally ☐ Night ☐ As a profession
- ❖ If there were an opportunity to reduce or eliminate your need for reading glasses or bifocals after cataract surgery with premium lenses, even if there was an out-of-pocket expense, would you be interested in learning more? ☐ Yes ☐ No

****** Please check any of the following activities that you do on a regular basis: ******

☐ Read Newspaper / Books	☐ Musician / Choir	☐ Drive Daytime
☐ Needlepoint	☐ Shop	☐ Drive Nighttime
☐ Paperwork	☐ Play Cards / Dominos	☐ Hunt / Fish
☐ Read Medicine Bottles	☐ Dine out / Cook	☐ Bicycle
☐ Use Computer / PDA	☐ Paint / Artist	☐ Golf / Tennis
☐ Photography	☐ Theatre	☐ Spectator Sports

****** Circle the above activities you would like to do without glasses if possible. ******

- ❖ What occupational, recreational or other activities are you currently engaged in that are not listed?

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Patient's Signature ________________________________ **Doctor's Initials:** _______