

# Lifestyle Vision® Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

We recognize that your eyes are very important to you. We would like to know how *you* use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal **Lifestyle Vision**.

- Do you wear glasses now? \_\_\_ No If Yes: \_\_\_ All the time \_\_\_ Sometimes  
 \_\_\_ Only for far distance \_\_\_ Only for reading \_\_\_ Only for the computer

**Check the following activities you do on a regular basis:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Read Newspapers/Books     | <input type="checkbox"/> Read Medicine Bottles | <input type="checkbox"/> Needlepoint/Sew   | <input type="checkbox"/> Participate in Water Sports |
| <input type="checkbox"/> Drive – Daytime           | <input type="checkbox"/> Drive – Nighttime     | <input type="checkbox"/> Shop              | <input type="checkbox"/> Use iPhone/Blackberry       |
| <input type="checkbox"/> Play Tennis               | <input type="checkbox"/> Hunt or Fish          | <input type="checkbox"/> Paint/Draw        | <input type="checkbox"/> Watch Spectator Sports      |
| <input type="checkbox"/> Play a Musical Instrument | <input type="checkbox"/> Dine in Restaurants   | <input type="checkbox"/> Bicycle           | <input type="checkbox"/> Play Cards/Dominos          |
| <input type="checkbox"/> Use the Computer          | <input type="checkbox"/> Golf                  | <input type="checkbox"/> Use Cell Phone    | <input type="checkbox"/> Watch Movies in Theatre     |
| <input type="checkbox"/> Photography               | <input type="checkbox"/> Cook                  | <input type="checkbox"/> Paperwork/Writing |  |

**Underline the above activities you would like to do *without glasses*, if possible. (To underline, highlight text, right click and select “Underline Text.”)**

- How important is it for you to read or use the computer without glasses?  
 \_\_\_ Very important \_\_\_ Important \_\_\_ Not important
- How many hours per day do you: Read? \_\_\_\_\_ Use the computer? \_\_\_\_\_
- Where do you hold your book when reading? \_\_\_ Close to your face \_\_\_ Chest level \_\_\_ In your lap
- How do you feel about wearing glasses? \_\_\_\_\_
- If it were possible to go without glasses most of the time, would you like that? \_\_\_ No \_\_\_ Yes
- Do you drive at night? \_\_\_ No If Yes: \_\_\_ Occasionally \_\_\_ Nightly \_\_\_ As profession (truck, cab, etc.)
- What occupational, recreational, or other activities do you currently engage in that are not listed above?  
 \_\_\_\_\_

Please place an “X” on the following scale to describe your personality as best you can:

<b>Easy going</b>									<b>Perfectionist</b>