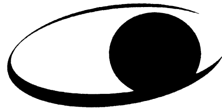

Your Visual Lifestyle Questionnaire

Name: ____ *Date:*___________________

Please complete the following form to help your doctor better understand your visual needs at home, at work and during recreation.

Please check ALL of those that apply to you:

[ ] Wear eyeglasses fulltime
[ ] No backup pair of eyeglasses
[ ] Use more than one pair of eyewear
[ ] Problems with the fit or comfort of your eyewear
[ ] Interested in thinner and lighter eyewear
[ ] Interested in no-line bifocal lenses
[ ] Interested in reducing glare and reflections from your lenses
[ ] Problems with scratched lenses
[ ] Bifocals interfere with watching TV

[ ] Uncomfortable in bright sunlight
[ ] Not wearing sun protection outside
[ ] Uses prescription sunglasses
[ ] Uncomfortable driving at night
[ ] Headlights bother you at night
[ ] Difficulty seeing at night

[ ] Use a computer at home or work on a regular basis
[ ] Eyestrain, neck or shoulder discomfort at the computer
[ ] Tilt your head back to see the computer clearly
[ ] Wear dedicated eyewear for the computer
[ ] Wear industrial safety eyewear at work
[ ] Work or play in any hazardous situations

[ ] Uncomfortable in wearing eyeglasses
[ ] Current contact lenses wearer
[ ] Previous contact lens wearer
[ ] Interested in a "Test Drive" of the latest contact lenses
[ ] Interested in bifocal contact lenses
[ ] Interested in information on Laser Vision correction

Circle those activities/hobbies that apply to you:

Baseball
Basketball
Boating
Card Playing
Computer
Computer Games
Coin Collecting
Drawing
Flying
Fishing
Football
Gardening
Golf
Hunting
Jogging
Knitting
Painting
Photography
Piano or Organ
Puzzles
Needlework
Racquetball
Reading
Scrapbooking
Scuba Diving
Sewing
Skiing
Soccer
Stamp Collecting
Swimming
Travel
Tennis
Walking
Word Puzzles
Workshop/Woodworking