Patient Lifestyle Supplement

Patient Name:_____Date:_____

Your responses to the following questions will help us to make the best recommendations for your eye care needs.

Current Satisfaction with Your Vision: (circle one)

If you wear *contacts*, are you satisfied with the vision and comfort? **Yes No**
If you wear *glasses*, are you satisfied with the vision and comfort? **Yes No**
If you wear *bifocals*, are you bothered by the lines or head tilting? **Yes No**
Do you have more than one pair of current prescription glasses? **Yes No**

Preferences and Interests:

If you wear contact lenses, what kind?_____
What type of cleaning solution do you use?_____
Are you interested in color contacts?_____
If you don't currently wear contacts, have you ever tried them?_____
Would you be interested in a trial pair of the latest in contact lens design?_____
Are you interested in a thinner, lighter lens for eyeglasses?_____
Do you prefer not to wear your glasses at times?_____
Would you like information on Laser Vision Correction?_____
Are you interested in a new non-surgical approach to vision correction?_____

Lifestyle Factors:

Do you…

Work often at a computer? **Yes No**

If Yes, How far is your computer monitor from your eyes? _____

Spend much time outdoors? **Yes No**

Have prescription sunglasses? **Yes No**

Have 100% UV protection in your sunglasses (whether prescription or not)? **Yes No**

Have family members in need of eye care? **Yes No**

_____ Age _____
_____ Age _____
_____ Age _____

Have hobbies that strain your eyes? **Yes No**

Experience eye discomfort due to seasonal or environmental allergies? **Yes No**

Work in a hazardous environment such as manufacturing? **Yes No**

Have an east-west commute? **Yes No**

Drive often at dusk, dawn, or nighttime? **Yes No**

Spend a lot of time in areas with low lighting? **Yes No**

If you wear contacts, do you have a "backup" pair of eyeglasses? **Yes No**