



## Patient Lifestyle Questionnaire

I work...

indoors

outdoors

What type of setting? \_\_\_\_\_

My job requires travel. (Check all that apply.)

driving

flying

both

How much time do you spend each day at a computer?

0-1 hour

3-5 hours

1-3 hours

5+ hours

How much time do you spend driving at night? \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

What type of outdoor activities do you participate in? (Check all that apply.)

Golfing

Biking

Hiking

Boating

Skiing

Jogging/Walking

Gardening

Team Sports

Other

Are you interested in contact lenses for any reason or activities?

Yes

No

Are you concerned about protecting your eyes from harmful UV rays?

Yes

No

What did you like about your last pair of glasses? \_\_\_\_\_

\_\_\_\_\_

What would you change? \_\_\_\_\_

\_\_\_\_\_

What do you currently use for sunwear? \_\_\_\_\_

\_\_\_\_\_

What did you like about your last pair of sunglasses? \_\_\_\_\_

\_\_\_\_\_

What would you change? \_\_\_\_\_

\_\_\_\_\_

Would you like information about LASIK surgery?  Yes  No

Do you have a backup pair of glasses?  Yes  No

Do you have glare while driving at night or on your computer screen?  Yes  No