Patient Lifestyle Questionnaire – Spectacles

Patient Name:_____ Date of Visit: _____

Occupation: _____

1. Which of the following visual demands do you encounter on a regular basis? (Check all that apply)

	Computer Work		Potential Eye Hazards
	Extended Paperwork		Artificial Lighting
	Extended Reading		Natural Lighting
	Board Work		Other:

2. Which of the following hobbies or activities do you participate in? (Check all that apply)

	Golf		Exercise/Running/Walking
	Biking		Fishing/Hunting
	Boating/Water Sports		Team Sports
	Sewing/Arts/Crafts		Extended Driving
	Motorcycle		Other:

3.Do your eyes ever seem bothered by glare from any of the following? (Check all that apply)

	Car Headlights		Night Driving
	Computer Monitor		Sunshine
	Fluorescent Lights		Traffic Lights
	Haze		Other:

4.What do you like about your current glasses? (Color, style, fit?)

5. What don't you like about your current glasses? (Weight, thickness, glare?)

6. Any metal/silicone allergies?