Lifestyle Vision Questionnaire

Carolina Vision Center

Name: Date:

We know 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 information will assist us in recommending the best options for your eyes and your personal lifestyle vision.

Do you wear glasses now? □ Yes □ No

If Yes: □ All the time □ Sometimes
□ Only for distance □ Only for reading □ Only for computer

How important is it for you to read or use the computer without glasses?
□ Very important □ Important □ Somewhat important □ Not important

If it were possible to go without glasses for most of the time, would you like that?
□ Yes □ No

How many hours per day do you: Read _____ Use a Computer _____

Do you drive at night? □ Socially □ Occasionally □ As a profession

Have you ever considered LASIK? □ Yes □ No

Have you ever considered contact lenses? □ Yes □ No

Have you heard about or discussed Premium Multifocal Lenses with anyone? □ Yes □ No

Check the following activities you do on a regular basis

□ Read newspapers, books	□ Read medicine bottles	□ Needlepoint	□ Golf
□ Drive - daytime	□ Drive - nighttime	□ Shop	□ Cook
□ Bicycling, Roller blades, etc.	□ Hunt or fish	□ Paint / Artist	□ Musician
□ Dine in restaurants	□ Play cards / dominos	□ Tennis	□ Water sports
□ Travel	□ Spectator sports	□ Movie theatre	□ Photography

Underline the above activities that you would like to do without glasses if possible.

What occupational, recreational or other activities do you currently engage in that aren't listed?

_____

_____

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

Easy going Perfectionist