INDIAN SPRINGS

EYE ASSOCIATES

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
☐ 1-3 hours
☐ 3-5 hours
☐ 5+ hours

How much time do your spend driving at night? _________ Hours _________ Minutes

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

☐ Golfing
☐ Boating
☐ Gardening
☐ Biking
☐ Skiing
☐ Team Sports
☐ Hiking
☐ Jogging/Walking
☐ 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