**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?