LIFESTYLE AND VISUAL QUESTIONAIRE

Patient Name: _____________________________________ **Date:** ____________________

If employed, what is your occupation? ____

What activities do you enjoy or do frequently?

_____Reading _____Computer _____watching TV

_____Sewing _____shopping _____driving

_____Playing cards _____cooking _____watching/playing sporting events

Other (please list): ____

____

Do you have difficulty with any of the following activities?

_____Reading, sewing or any other near activities _____working on my computer

_____Seeing/reading road signs at a proper distance _____ seeing shopping labels

_____recognizing faces or seeing the clock across the room

Other: ____

Have you experienced any of the following?

_____halos, glare or difficulty seeing at night _____difficulty with color perception

_____difficulty with depth perception _____overall decrease in vision

Other: ____

Place an "X" on the line/scale below to describe your motivation to reduce your dependency on glasses:

____

I don't mind wearing glasses at all I would do anything to avoid wearing glasses

Do you take your glasses off to read? Yes No

Place an "X" on the line/scale below to describe your personality as best you can:

____

Easygoing Perfectionist

Patient Signature: ____________________________________ 8-19-14