

**LIFESTYLE AND VISUAL QUESTIONNAIRE**

**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:** \_\_\_\_\_