**LIFESTYLE AND VISUAL QUESTIONAIRE**

**Patient Name**: _____ **Date of Birth:_____ Today's 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:**

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I don't mind wearing glasses 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:**

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Easygoing Perfectionist

**Patient Signature:** _____