Lifestyle Vision Questionnaire

Susan Longar, MD Peter Martindale, OD

Name_____ Date_____

We recognize that your eyes are very important to you. We would like to know how <u>you</u> use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

Do you wear glasses or contacts now? ____No if Yes____ All the time____ Sometimes____ Only for far distance____ Only for reading____ Only for computer

How important is it for you to read or use the computer without glasses or contacts? ____Very important ____ Important ____ Not important

How many hours per day do you; read? ____ use computer? ____

Where did you hold your book when reading? ____ Close to face____ Chest level____ In your lap

How do you *feel* about wearing glasses or contacts? _____

If it were possible to go without glasses or contacts for most of the time, would you like that? Yes__ No__

Do you drive at night? ____ No if Yes____ Occasionally ____ Nightly ____ As profession (truck, cab)

<u>Circle the following activities you do on a regular basis:</u>

Cell phone	I-Pad / Tablet	Computer (Lap Top)	Computer (Desk Top)
Drive daytime	Drive nighttime	Read newspaper, books	Reading menu's
Read medicine bottles	Hunt or Fish	Paint / Artist	Photography
Play cards	Bicycle / Running	Musician	Shop / Read tags
Paperwork/Writing	Cook	Movie theater	Golf / Tennis
Spectator Sports			

<u>Underline</u> the above activities that you would like to do <u>without glasses if possible</u>

What occupational, recreational, or other activities do you currently engage in that are not listed above?

_____

A guide to your visual health

Please check the statements below that apply to you and share this list with your doctor. Check “yes” if you agree with the statement.

Yes No

___ ___I need to drive, but there is too much glare from the sun or headlights

___ ___I do not see well enough to do my best at work

___ ___I do not see well enough to do the things I need to do at work

___ ___I am afraid that I will bump into something or fall

___ ___Because of my cataract, I am not as independent as I would like to be

___ ___My eyeglasses do not help me see well enough

Please describe limitations with your vision:

_____
_____
_____
_____
_____
_____

Yes No

___ ___I am interested in Botox cosmetic

___ ___I am interested in Juvederm

___ ___I am interested in eyelid surgery

___ ___I am interested in longer, thicker lashes

___ ___I am interested in contact lens fitting

A guide to your visual health

Please check the statements below that apply to you and share this list with you doctor. Check "yes" if you agree with the statement.

Yes	No	
___	___	I need to drive, but there is too much glare from the sun or headlights
___	___	I do not see well enough to do my best at work
___	___	I do not see well enough to do the things I need to do at home
___	___	I am afraid that I will bump into something or fall
___	___	Because of my cataract, I am not as independent as I would like to be
___	___	My eyeglasses do not help me see well enough

Please describe specific limitations with your vision:

_____
_____
_____
_____
_____

Yes	No	
___	___	I am interested in Botox cosmetic
___	___	I am interested in Juvederm
___	___	I am interested in cosmetic eyelid surgery (blepharoplasty)
___	___	I am interested in Latisse (medication to help lengthen eyelashes)
___	___	I am interested in contact lens fitting

2016/JM