



# LIFESTYLE QUESTIONNAIRE

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**OCCUPATION** \_\_\_\_\_ **YEARS** \_\_\_\_\_ **EMPLOYER** \_\_\_\_\_

This questionnaire is designed to assist your eye care professional in helping you select the appropriate lenses, frames and/or contact lenses to suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

**1. Which of the following activities do you participate in? (Check all that apply)**

- |                 |                                |                                     |                                       |
|-----------------|--------------------------------|-------------------------------------|---------------------------------------|
| Reading         | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Watching TV     | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Driving         | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Sports/Exercise | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |

- Computer  Desktop      Hours per day \_\_\_\_\_  
 Laptop      Distance from screen \_\_\_\_\_  
 Handheld      (iPhone, Blackberry, etc.)

- Arts/Crafts
- Boating
- Drawing/Painting
- Fishing
- Hunting/Shooting
- Landscaping/Gardening
- Musical instrument
- Photography
- Pilot
- Sewing
- Video Games
- Woodwork
- Other: \_\_\_\_\_

**Hobbies** ←  
 → **Sports**

- Biking
- Golf
- Running
- Scuba-diving
- Skiing
- Swimming
- Tennis
- Other: \_\_\_\_\_

**2. Are your eyes bothered by glare from any of the following situations:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Car headlights     | <input type="checkbox"/> Haze          | <input type="checkbox"/> Sunshine       |
| <input type="checkbox"/> Computer monitor   | <input type="checkbox"/> Night driving | <input type="checkbox"/> Traffic lights |
| <input type="checkbox"/> Fluorescent lights | <input type="checkbox"/> Snow          | <input type="checkbox"/> Other:         |

**3. What do you like about your current glasses or contacts? (color, style, fit, etc.)**

**4. What don't you like about your current glasses or contacts? (thickness, glare, etc.)**