



Vision & Your Lifestyle

Please take a moment to complete this questionnaire so we can better understand your daily vision needs. Thank you!

Occupation

What is your occupation? _____

How many hours do you spend reading on a daily basis? _____

How many hours do spend working on a computer on a daily basis? _____

Check one:

Do you work in Bright Light _____ Medium Light _____ Low Light _____?

Do your eyes feel tired or strained at the end of the workday?

Yes _____ No _____

Recreation

Do you experience sensitivity to light? Yes _____ No _____

Does glare bother you? Yes _____ No _____

Do you spend time outdoors? _____ Avg hours/week

Do you participate in any contact sports? Yes _____ No _____

Do you wear sunglasses with UV protection? Yes _____ No _____

Does driving at night bother you? Yes _____ No _____

Do you think you will benefit from thinner, lighter lenses? Yes _____ No _____

Do you have a hard time viewing 3-D movies? Yes _____ No _____

Leisure Activities:

___ Tennis

___ Sports

___ Racquetball

___ Jogging/Walking/Hiking

___ Boating

___ Snow Skiing

___ Fishing

___ Hunting

___ Drawing/Painting

___ Golfing

___ Needlework/Sewing

___ Public Speaking

___ Woodwork/Furniture refinishing ___ Other: _____

General

Are you interested in Contact Lenses? Yes _____ No _____

Are you a current Contact Lens wearer? Yes _____ No _____

If yes, rate your Contact Lens experience from 1-10. _____

If not a 10, what could make your experience better?

Do you have more than 1 pair of current Rx eyewear? Yes _____ No _____

Do you have Children? Yes _____ No _____

Do you have any family members in need of eyecare? Yes _____ No _____