Lifestyle Questionnaire

Name: ____________________________ Date: ____________________________

How did you first hear about us? Patient: ____________________________ Insurance: ____________________________ Website: ____________________________

Doctor: ____________________________ Billboard: ____________________________ Radio: ____________________________

Your eyes are very important and we would like to know how you use your eyes on a daily basis. Along with your eye exam, this information will assist us to recommend the best options for your personal visual goals.

- Do you wear glasses now? □ No  If Yes: □ All the time □ Sometimes □ Only for Far Distance
  □ Only for Reading □ Only for the Computer

- Do you have a particular motivation for wanting laser vision correction? ____________________________

- Do you drive at night? □ Often □ Occasionally

Check the following activities you do on a regular basis:

- □ Bicycle
- □ Childcare
- □ Computer
- □ Cook
- □ Golf
- □ Hiking
- □ Hunt / Fish
- □ Motorcycle
- □ Movies / Theatre
- □ Musician
- □ Needlepoint / Sew
- □ Paint / Draw
- □ Photography
- □ Play Cards / Dominos
- □ Read books/paper
- □ Recreational Sports
- □ Star gazing
- □ Spectator sports
- □ Swim / Water Sports
- □ Television
- □ Tennis

Underline the above activities that, if possible, you would like to do without glasses/contacts.

Any other regular activities not listed? ____________________________

What has prevented you from proceeding with laser vision correction before now?

□ Budget □ Fear □ Changing Prescription □ Timing

How soon do you want to have your surgery done? ____________________________

Place an “X” on the scale below that best describes your personality:

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Easy going  Perfectionist