Patient Lifestyle Questionnaire

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us to better understand your vision care needs.

What is your professional environment? (Check all that apply.)

___I work in a professional business office. ___My job requires travel (driving/flying/both).

___I work from home. ___I work outside most of the time.

How much time do you spend each day at a computer?

___0-1 Hour ___1-3 Hours ___3-5 Hours ___5+ Hours

How much time do you spend driving at night? (hours/minutes)

What type of outdoor activities do you participate in? (Check all that apply.)

__Golfing __Gardening __Skiing __Hiking __Jogging/Walking __Boating __Biking __Team Sports __ Other

What are your indoor hobbies?

__Reading __Arts/Crafts __Sewing/Knitting __Other

Please list any skin allergies.

Are you concerned about protecting your eyes from harmful UV rays? ___Yes ___No

What do you currently use for sunwear?

What did you like about your last pair of glasses?

What would you change?

What did you like about your last pair of sunglasses?

What would you change?