

# 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.
- I work outside most of the time.
- My job requires travel. (driving / flying / both?)
- I work from home.

**How much time to you spend each day at a computer?**

- 0-1 Hour                       3-5 Hours
- 1-3 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
- Jogging / Walking                       Boating                       Biking
- Hiking                       Team Sports                       Other

**What are your indoor hobbies?**

- Reading                       Sewing / Knitting
- Painting / Drawing                       Crafting
- Other

**Please list any skin allergies:** \_\_\_\_\_

**What did you like about your last pair of glasses?** \_\_\_\_\_

\_\_\_\_\_

**What would you change?** \_\_\_\_\_

\_\_\_\_\_

## OFFICE USE ONLY

Patient Name: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

**Vision Care Recommendations:**

Frames \_\_\_\_\_

Lenses \_\_\_\_\_

Contacts \_\_\_\_\_

Sunglasses \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_