Lifestyle Vision Questionnaire Lippman Eyecare Centers

Name: _____ **Date:** _____

We recognize that your eyes are very important to you. We would like to know how *you* use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

- Do you wear glasses now? _____No _____ Yes
  If Yes _____ All the time _____ Sometimes

  _____Only for distance _____Only for reading _____ Only for computer

- How important is it for you to see to read or use computer without glasses?
  Very important_____ Important_____ Somewhat important_____ Not important_____

- If it were possible to go without glasses for most of the time, would you like that?
  Yes_____ No____

- How many hours per day do you: read? _____ use computer? _____

- Do you drive at night? Socially _____ Occasionally_____ As profession_____

Check the following activities you do on a regular basis:

↑Read newspaper, books ↑Read medicine bottles ↑Needlepoint ↑Wall Street Journal

↑Drive daytime ↑Drive nighttime ↑Shop ↑Golf

↑Tennis	↑Hunt or Fish	↑Paint / Artist	↑Cook
↑Musician	↑Play Cards / Dominos	↑Bicycling, Roller blades, etc	
↑Photography	↑Spectator Sports	↑Movie theatre	↑Dine in Restaurant

<u>Underline</u> the above activities that you would like to see *<u>without glasses if possible</u>*

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

Please place an "X" on the following scale to describe your personality as best you can:

Easy going Perfectionist