Patient Lifestyle Questionnaire

Name: _____ **Age**:_____ **Date**:_____

To better help your physician treat your visual difficulties, please check the following that apply:

I wear: Contacts Glasses None

Occupation was:_____/**Is**:_____

Whether I wear my glasses, contacts, or not, I enjoy:

Near:

- ☐  Reading
- ☐  Crossword
- ☐  Knitting/Sewing
- ☐  Fishing
- ☐  Playing Cards

Intermediate:

- ☐  Painting
- ☐  Computer Work
- ☐  Cooking
- ☐  Gardening
- ☐  Playing Piano

Distance:

- ☐  Golfing
- ☐  Playing Tennis
- ☐  Sailing
- ☐  Bowling
- ☐  Running

- ☐  Driving
- ☐  Bike Riding
- ☐  Watching TV
- ☐  Fishing
- ☐  Walking

Other activities I enjoy: 1._____ 2. _____ 3. _____

I currently have problems with:

Glare	Halos around lights	Blurred vision	Hazy vision
Headaches	Seeing in dim light	Poor night vision	Tired eyes

How did you hear about Surgical Eye Care & Dr. Brown? _____

*****FOR OFFICE USE ONLY*****

Premium lenses that offer additional benefits are now available for many of our patients. Traditional insurance plans typically do not cover the added costs for these new lenses. It is important you fully understand the benefits of the lenses and we will ask you to sign below at the end of your exam.

☐ I wish to have the recommended lens

☐ I **do not** wish to have the recommended lens

Patient Signature_____ Date _____