

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

Underline the above activities that you would like to see *without glasses if possible*

- 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