CENTER FOR SIGHT

Visual Lifestyle Questionnaire

Name _____ Date _____

Our mission at Center for Sight is to provide you with the highest quality of personalized eye care available. In order to do so, we need to learn about your individual needs and preferences. The following questions are intended to help us, help you.

Are you currently: (Please check all that apply)

Retired? _____ Employed? _____
Homemaker? _____ Student? _____

If you are employed, what is your occupation? _____

Please tell us how you use your eyes in the pursuit of your lifestyle.

During an average day, how many hours do you spend reading or doing close work? _____

How many pairs of glasses do you currently use? (Please include sunglasses and over-the-counter readers.) _____

How far is the reading or close work material from you? (Check all that apply)

- ❑ 12-14 inches (holding a book or sheet of paper)
- ❑ 24 inches (arms length)
- ❑ Further than 24 inches, but less than 20 feet

How wide is the reading material or close work? (Check all that apply)

❒ Standard page (8½ x 11) ❒ Newspaper Width ❒ Book Width

How would you describe the lighting where you do most of your reading?

❒ Low ❒ Adequate ❒ Bright ❒ Contrast ❒ Glare

How many hours during an average day do you use a computer? _____

Do you experience back, neck, shoulder or eye discomfort when using a computer? ❒ Yes ❒ No
(Note: Back, neck and shoulder pain can be attributed to the position of your workspace)

Do you ever perform any work or read things above eye level or over your head?
(examples: garage mechanics, plumbers, carpenters, etc.) ❒ Yes ❒ No

Are you required to wear safety glasses at work? ❒ Yes ❒ No

Are you bothered by glare during the day or at sunrise/sunset? ❒ Yes ❒ No

Do you have prescription sunglasses? ❒ Yes ❒ No

Are they polarized? ❒ Unsure ❒ Yes ❒ No

Do you notice halos or glare from headlights or streetlights at night? ❒ Yes ❒ No

Please complete the back side of this survey.

What activities or hobbies do you engage in? (Check all that apply)

Seldom	Frequently	
_____	_____	Reading
_____	_____	Painting
_____	_____	Sewing / Needlecrafts
_____	_____	Yard work / Gardening
_____	_____	Home workshop
_____	_____	Walking / Running
_____	_____	Cycling
_____	_____	Motorcycle Riding
_____	_____	Shooting / Hunting
_____	_____	Swimming / Scuba / Snorkeling
_____	_____	Boating / Fishing
_____	_____	Flying
_____	_____	Golf
_____	_____	Tennis
_____	_____	Sports: basketball, hockey, soccer, football, baseball
_____	_____	Other: _____

Does your work or after work activities cause you to go from indoors to outdoors frequently? ❒ Yes ❒ No

Do you have any skin allergies to metal? ❒ Yes ❒ No

Have you ever felt your eyeglass lenses were (Check all that apply):

- ❑ Too thick / too big?
- ❑ Too heavy?
- ❑ Too scratched?
- ❑ Made your eyes look larger / smaller?

What do you like most about your present glasses? _____

What do you like least about your present glasses? _____

What one aspect of your visual lifestyle do you wish your new eyeglasses could improve? _____

_____

Have you ever wished you could see clearly without eyeglasses or contact lenses? ❒ Yes ❒ No

(Please do not write beyond this point)

Technician's Notes to the Doctor:

- ❒ Progressive lens for _____
- ❒ A/R for _____
- ❒ Polarized Sunwear for _____
- ❒ Computer / Office Lens for _____
- ❒ Transitions / Drivewear for _____
- ❒ Safety Glasses for _____
- ❒ Other: _____

Technician _____ Date _____