Lifestyle Vision Questionnaire CT Eye Specialists, LLC

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 lens option(s) to enable us to provide you with the most useful vision following any upcoming eye surgery that you may be considering undergoing.

- Do you wear glasses now? ____No If Yes: ____ All the time ____ Sometimes
  ____Only for far distance ____Only for reading ____ Only for computer

- How desirable is it for you to read or use computer without glasses?
  ____Very Desirable ____ Desirable ____ Not important

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

- Where do you hold book when reading? ____ close to face ____ chest level ____ in your lap

- Percentage of reading in bright light (outdoors) _____% vs. low light settings (menu, bedtime)_____ % ?

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

- Do you drive at night? ___No If Yes: ___Occasionally ___ Nightly ____As profession (truck, cab)

Circle the following activities you do on a regular basis:

□ Read Newspaper, Books, Labels (daytime / nighttime / day or night) □ Sew/Needlepoint

□ Computer-desktop □ iPad or Laptop □ Cell Phone □ Paperwork / Writing

□ Drive daytime □ Drive nighttime □ Shop □ Golf

□ Kindle / Nook □ Hunt or Fish □ Paint / Artist □ Cook

□ Musician □ Play Cards □ Bicycle, swim, jog Hike, etc

□ Photography □ Spectator Sports □ Movie theatre □ Dine in Restaurant

Place a Star above activities that you would like to do *without glasses if possible*

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

- Would you be willing to pay out of pocket for a better lens to maximize the flexibility of your vision?

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

Easy going Perfectionist