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LIFESTYLE QUESTIONNAIRE

Our goal at Eye Specialists of Westchester is to provide our patients with quality eyewear that will meet all of their lifestyle needs. Over the years, there have been major advances in frame and lens technologies. With these advances, we are given the opportunity to better assist our patients in purchasing eyewear that will perform to their expectations yet be comfortable and stylish.

In helping us to ensure that the eyewear you receive will enable you to successfully perform all of your daily activities, whether it be for work or play, we request that you fill out this brief questionnaire. This information will allow us to better assist you in making the eyewear choices most beneficial to your lifestyle.

Name_____Date completed_____

Occupation_____ Age_____ Sex ☐ Male ☐ Female

1. Do you currently wear eyeglasses? ☐ Yes ☐ No
   If Yes, for what purpose?_____

2. Which of the following visual demands do you encounter on a regular basis?
   (check all that apply)

☐ Artificial lighting	☐ Natural lighting	☐ Potential eye hazards
☐ Board work	☐ Night driving	☐ Reading
☐ Close-up work	☐ Paperwork	☐ Other_____
☐ Computer work		

LIFESTYLE QUESTIONNAIRE CONTINUED

3. Which of the following hobbies or activities do you participate in?
(check all that apply)

- ☐ Auto Repair
- ☐ Biking
- ☐ Boating/Water sports
- ☐ Bookkeeping
- ☐ Bowling
- ☐ Competitive sports
- ☐ Computer
- ☐ Drawing/painting
- ☐ Fishing
- ☐ Golf
- ☐ Home repairs
- ☐ Hunting/shooting
- ☐ Jogging/running
- ☐ Landscaping/gardening
- ☐ Musical instrument
- ☐ Racquetball
- ☐ Reading
- ☐ Sewing/arts/crafts
- ☐ Snow sports
- ☐ Spectator sports
- ☐ Tennis
- ☐ Watching TV
- ☐ Welding/woodwork
- ☐

Other_____

- ☐ Exercise

4. Do your eyes seem bothered by glare from any of the following situations?
(check all that apply)

- ☐ Car headlights
- ☐ Computer monitor
- ☐ Fluorescent lights
- ☐ Haze
- ☐ Night driving
- ☐ Street lights
- ☐ Sunshine
- ☐ Traffic lights
- ☐

Other_____

5. If you wear contact lenses, do you have?
(check all that apply)

- ☐ Current pair of prescription eyeglasses
- ☐ Current pair of prescription sunglasses

6. Do you have metal and/or latex allergies?

- ☐ Yes ☐ No

7. Are your lenses scratched or damaged from regular use? ☐ Yes ☐ No
8. Do you spend more than one hour per day in the sun? ☐ Yes ☐ No
9. Are your current eyeglasses uncomfortable or do they cause indentations on your nose? ☐ Yes ☐ No

10. What improvements do you want in your new eyewear?