East Bay Optometry Lifestyle Questionnaire

Patient Name: _____ Date of Visit: _____
Occupation: _____

This questionnaire is to assist your eye care professional in helping you select the perfect lenses, frames, and/or contacts to best suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

1. Which of the following visual demands do you encounter on a regular basis? (Check all that Apply)

	Computer work		Board work
	Paperwork		Potential eye hazards
	Reading		Artificial lighting
	Close-up work		Natural lighting

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

	Auto Repair		Landscaping/ Gardening
	Biking		Musical Instrument
	Boating		Painting
	Book keeping		Pilot
	Bowling		Racquetball
	Competitive Sports		Reading
	Computer		Sewing/ Arts/ Crafts
	Drawing		Snow Sports
	Driving		Spectator Sports
	Exercise		Tennis
	Fishing		Watching TV
	Golf		Welding
	Home Repairs		Woodwork
	Hunting/ Shooting		Other (describe)
	Jogging/ Running		

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

	Car Headlights		Night driving
	Computer monitor		Sunshine
	Fluorescent lights		Traffic lights
	Haze		Other (describe)

4. If you wear contacts, do you have any of the following? (Check all that apply)

	Current pair of prescription glasses
	Sunglasses (purchased at a boutique, department store/Optical store)

5. Do you have any metal or silicon allergies?
O Yes O No

6. What do you like about your current glasses or contacts? (Color, Style, Fit, etc)?

_____
_____

7. What don't you like about your current glasses or contacts? (Weight, thickness, glare, etc)?
_____
_____