Lifestyle Considerations for
____ (name)

What is *or* was your **occupation**?
____

Please list your **favorite hobbies**?
____

Do you use a **computer** frequently? YES NO

Do you do a lot of **close detailed work**? YES NO

Have you ever tried **monovision** contact lenses? YES NO
If "yes", did/do you like it? YES NO

Do you wear progressive/no-line **bifocals** now? YES NO

Have you had **LASIK/ LASEK/RK?** YES NO

Do you suffer with **dry eyes**? Do you feel it affects your vision?

____
____

How do you feel about wearing glasses? (please check all that apply)

____ I don't mind wearing glasses **all day**.

____ I don't mind wearing glasses **for reading /close work**.

____ I don't mind wearing glasses **for TV/driving distances**.

____ I don't ever want to wear glasses

What is the most important thing you want the doctor to understand about you and about your vision? In what areas is your vision impacting your life (reading, TV, driving, etc.)

____

____

Patient Signature: ______________________________________

Date: ______________________