Lifestyle Questionnaire

PLEASE CIRCLE OR CHECK THE RESPONSE WHICH MOST APPLIES TO YOU

OCCUPATION:_____**/If Retired Prior Occupation:**_____

1. I currently wear: □ Eyeglasses □Contact lenses □ Hearing Aid (s)

2. My primary vision needs are: □ Distance □ Reading □ Arms Length

3. I have difficulty seeing clearly: □ In bright light □ Driving at night □ In the rain/low light

4. I wear Rx/non-Rx sunglasses: □ Daily □ Sometimes □ Rarely □ Never

5. I am interested in info. about: □ Sun wear □ Sport wear □ Reading wear □ Contacts
□ Lasik □ Hearing aid (s) □ Cosmetic eye surgery

6. I am: **Light Sensitive (outdoors, driving, during active times/sports)**……...Yes No

7. I spend: **% of my day on the computer** 0%…..10%…...25% ……50%…...>50%

8. I have: **Pair (s) of eyeglasses that I currently use**……..……1 2 3 4 5

9. What recreational hobbies or activities do you enjoy? Check all that apply.

□Golf □Tennis □Boating □Racquetball □Fishing □Cooking
□Running □Snow Skiing □Football □Baseball/Softball □Basketball □Water sports
□Reading □Watching TV □Internet □Crafts □Painting □Gardening
□Knitting □Woodworking □Sewing □Video Games

10.What job requirements do you have? Check all that apply.

□Computer work □Outdoors work □Considerable Reading
□My job requires safety eyewear □I work under fluorescent lighting
□Other_____

11. I drive a car Yes No

12. I read a lot of fine print Yes No

13. I currently wear bifocal lenses Yes No

14. I currently wear progressive lenses (No line bifocals) Yes No

15. I am interested in learning more about reducing my dependence on glasses Yes No

16. Do you have imbalance, dizziness, or unsteadiness? Yes No

17. Do you experience ringing or sounds in your ears? Yes No

18. Do you have difficulty hearing people when someone speaks in a whisper? Yes No

19. Do you have difficulty hearing in a loud room or in groups? Yes No

20. Do you have difficulty hearing the TV or radio? Yes No

21. My hearing limits or hampers my personal or social life Yes No

22.Are you interested in having your hearing or balance evaluated ? Yes No

(This is covered by most insurance plans)

Cape Coral EYE CENTER

Lifestyle Questionnaire

Name:_____

Sex: M F DOB: _____ Age: ____

Date: _____ Acct# _____