Lifestyle Questionnaire

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.

Patient Name _____ Date of Visit _____

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

☐ Paperwork	☐ Reading	☐ Close-up work
☐ Computer work	☐ Boardwork	☐ Potential Eye Hazards
How many hrs/day?	☐ Artificial Lighting	☐ Other :
_____	☐ Natural Lighting	_____

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

☐ Auto Repair	☐ Drawing	☐ Musical Instruments	☐ Spectator Sports
☐ Baseball/Softball	☐ Driving	☐ Painting	☐ Tennis
☐ Basketball	☐ Exercise	☐ Piloting/Flying	☐ Video Games
☐ Biking	☐ Fishing	☐ Racquetball	☐ Watching TV
☐ Boating/Water Sports	☐ Gardening	☐ Reading	☐ Welding
☐ Bowling	☐ Golf	☐ Running/Jogging	☐ Woodwork
☐ Competitive Sports	☐ Home Repairs	☐ Sewing/Arts & Crafts	☐ Other:
☐ Computer	☐ Hunting/Shooting	☐ Snow sports	_____

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:_____

4. Do you have any metal or silicon allergies? ☐ Yes ☐ No
5. Are you interested in contact lenses? ☐ Yes ☐ No
6. Are you interested in Gentle Vision Shaping Therapy (GVST) also known as Orthokeratology for you or
7. your child? GVST is a non-surgical, reversible vision correction using custom hard contacts to reshape the cornea.

☐ Yes ☐ No ☐ Not now, but I would like more information!