Patient Lifestyle Questions

Name: ____________________________________ Date of Birth: ____________Date:______________

REVIEW OF SYSTEMS (List past and present information)

Do you ….?	**YES**	**NO**	NOTES:
Work at a computer (If yes, please complete computer questionnaire)	☐	☐	________________
Think you might benefit from thinner, lighter lenses?	☐	☐	________________
Have interest in a "test drive" of the latest contact lens design?	☐	☐	________________
Spend time outdoors? How much? Hours per week?	☐	☐	________________
Have prescription sunwear?	☐	☐	________________
Prefer not to wear your glasses at times?	☐	☐	________________
Want information on Laser Vision Correction surgery?	☐	☐	________________
Have interest in a non-surgical approach to vision correction?	☐	☐	________________
Have more than 1 pair of Rx eyewear?	☐	☐	________________
Have children?	☐	☐	________________
Have family members in need of eyecare?	☐	☐	________________

Have you ever experienced or have been diagnosed and/or treated for any of the following?

- ☐ Blurry vision
- ☐ Cataracts
- ☐ Crossed eye/Eye turn
- ☐ Eye Infections
- ☐ Flash of light
- ☐ Glaucoma
- ☐ Headaches
- ☐ Itchiness
- ☐ Macular degeneration
- ☐ Retinal detachment
- ☐ Tearing
- ☐ Uncomfortable glasses
- ☐ Other Eye Disorders ______________________________
- ☐ Burning
- ☐ Corneal abrasions
- ☐ Double vision
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Iritis/Uveitis
- ☐ Lazy Eye
- ☐ Occasional dryness
- ☐ Sunlight sensitivity
- ☐ Trouble seeing at night

Physicians Signature ____ Date ________________

Physicians Signature ____ Date ________________

Physicians Signature ____ Date ________________