

# LIFESTYLE VISION QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle Initial

As the human eye ages, it gradually loses its ability to focus, making near vision tasks (computer, books, menus, etc) more difficult. We have many options available in treating your eyes to provide you with the best vision recommended for your specific visual demands. This questionnaire will assist us in providing the treatment best suited for your visual needs if it is determined that surgery is appropriate for you. It is important that you understand that many patients may need to occasionally wear glasses for some activities after surgery. Please fill this form out completely so the doctor can best assess your expectations, and recommend the best options available to you.

When do you wear your glasses/contact lenses?

- All the time       Only for distance       Only for reading/computer       Never

How many hours per day do you Drive? \_\_\_\_\_ Read? \_\_\_\_\_ Use the computer? \_\_\_\_\_

List activities and hobbies that you enjoy:

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What are your expectations with laser vision correction?

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Please place an "X" on the following scale to describe your personality as best you can:

{ -----X----- }  
Easy Going Perfectionist