Lifestyle Questionnaire

It is important to make sure your doctor has a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle and preferences.

Please fill out this questionnaire and bring it with you to your pre-operative assessment.

Date: D D / M M / Y Y Y Y

Name: ....

What is your occupation? ....

What hobbies, sports or other recreational activities do you enjoy?

....

....

Please share anything else you think might be important about your lifestyle or daily activities:

....

....

Please tick the activities you would prefer to do with less dependence on glasses:

- ☐ Reading books/newspapers
- ☐ Reading medicine labels
- ☐ Looking at your watch
- ☐ Viewing/dialing cell phone
- ☐ Knitting or needlepoint
- ☐ Applying makeup
- ☐ Shaving your face
- ☐ Card or table games
- ☐ Using a computer
- ☐ Night time driving
- ☐ Watching live sports
- ☐ Playing sport, like golf
- ☐ Watching TV
- ☐ Daytime driving
- ☐ Using a handheld tablet
- ☐ Other activities (List below)

....

Patient signature: ....

Staff initials: .... **Surgeon initials:** ....