Advanced Laser Vision & Surgical Institute Lifestyle Vision Questionnaire

Name: ____ **Date:** _______________

We recognize that your eyes are very important to you. We would like to know how *<u>you</u>* use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

- Do you wear glasses now? ____No If Yes: ____ All the time ____ Sometimes
  ____Only for far distance ____Only for reading ____ Only for computer
- How important is it for you to read or use computer without glasses?
  ____Very important ____ Important ____ Not important
- How many hours per day do you: read? ______ use computer? ______
- Where do you hold book when reading? ____ close to face ____ chest level ____ in your lap
- Percentage of reading in bright light (outdoors) _____% vs. low light settings (menu, bedtime)______ % ?
- How do you *feel* about wearing glasses?____
- If it were possible to go without glasses for most of the time, would you like that? ____No ____Yes
- Do you drive at night? ___No If Yes: ___Occasionally ___ Nightly ____As profession (truck, cab)

<u>Check the following activities you do on a regular basis:</u>

❑ Read newspaper, books	❑ Read medicine bottles	❑ Needlepoint	❑ Wall Street Journal
❑ Drive daytime	❑ Drive nighttime	❑ Shop	❑ Golf
❑ Tennis	❑ Hunt or Fish	❑ Paint / Artist	❑ Cook
❑ Musician	❑ Play Cards / Dominos	❑ Bicycle, Roller blades, etc	
❑ Computer	❑ Palm Pilot / Blackberry	❑ Cell Phone	❑ Paperwork / Writing
❑ Photography	❑ Spectator Sports	❑ Movie theatre	❑ Dine in Restaurant

<u>Underline</u> the above activities that you would like to do *<u>without glasses if possible.</u>*

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

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

Easy going Perfectionist