

Lifestyle Questionnaire

Patient Name: _____ Date: _____

Eye related to Complaints: **RIGHT** **LEFT** (please circle one)

YES **NO**

- Would you like your vision to be better?
- Do you have glare or halos around lights?
- Do you have double or distorted vision?
- Do you have difficulty with color vision?
- Do you have difficulty with depth perception or in going up or down stairs?
- Do you have difficulty driving? (seeing curbs, exits, traffic lights, road signs)
- Do bright lights cause a decrease in vision? (sunny days, bright lights)
- Does glare make driving difficult at night or have you stopped driving?
(halos around lights, car lights, street lights)
- Do you have difficulty seeing TV or movies? (faces, numbers or words)
- Do you have difficulty reading small print? (books, newsprint, a watch, medicine labels
computer or writing checks)
- Do you have difficulty performing handiwork? (sewing, knitting, wood-working, crochet)
- Do you have difficulty with leisure activities? (cards, bingo, golf, hunting, fishing, hobbies)
- Do you have difficulty performing routine activities at home? (phone dialing, cooking)
- Are you unable to recognize the faces of people? (in church, stores, clubs)
- Have you ever had Lasik or PRK surgery?
if yes, when & who was the surgeon? _____

Patient Signature: _____.