# Lifestyle Questionnaire

LUDWICK EYE CENTER

*Where Compassion Meets Excellence in Eye Care.*

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.

**Name:** _____ **Date of Birth:** _____

**Date of Visit:** _____ **Occupation?** _____

**What hobbies, outdoor or indoor recreational activities do you enjoy?**

_____

_____

**Do you do a lot of night time driving?** Yes No

**Would you prefer to do any of the following activities with less dependence on glasses?**

| | | | | | |
|---|---|---|---|---|---|
| Reading books/newspaper? | ❍ Yes | ❍ No | Card or table games? | ❍ Yes | ❍ No |
| Reading medicine labels? | ❍ Yes | ❍ No | Using a computer? | ❍ Yes | ❍ No |
| Shaving your face? | ❍ Yes | ❍ No | Using a handheld tablet device? | ❍ Yes | ❍ No |
| Applying make up? | ❍ Yes | ❍ No | Outdoor recreation (golf, hunting, sports, etc)? | ❍ Yes | ❍ No |
| Knitting/needlepoint? | ❍ Yes | ❍ No | Watching TV? | ❍ Yes | ❍ No |
| Viewing/dialing cell phone? | ❍ Yes | ❍ No | Driving: Day or night? | ❍ Yes | ❍ No |
| Looking at your watch? | ❍ Yes | ❍ No | Gardening? | ❍ Yes | ❍ No |