White Mountain
EYE CARE & OPTICAL
A department of Speare Memorial Hospital

Lifestyle Questionnaire

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Over the years, there have been many major advances in frames and lens technologies. With these advances, we are given the opportunity to better assist our patients in purchasing eyewear that will meet their lifestyle needs, perform beyond their expectations, and still be comfortable and stylish.

It is our goal to be "more than you expect." We will accomplish this goal by helping you select the perfect lenses, frames, and/or contact to suit your visual needs and lifestyle. Please assist in this process by completing this brief lifestyle questionnaire. This information will allow us to better assist you in making the eyewear choices most beneficial to you and your lifestyle.

Patient Name: Date of Visit:

Occupation: Age: Sex:

1. Do you currently wear eyeglasses? ☐ Yes ☐ No

   If yes, for what purpose?_____

2. Which of the following visual demands do you encounter on a regular basis? (Check all that apply)

☐ Artificial Lighting	☐ Natural Lighting	☐ Potential Eye Hazards
☐ Board Work	☐ Night Driving	☐ Reading
☐ Close-Up Work	☐ Paperwork	☐ Other_____
☐ Computer Work	☐ Outdoor Sun Light/Glare	

Lifestyle Questionnaire Continued

3. Which of the following hobbies or activities do you participate in? (Check all that apply)

☐ Auto Repair	☐ Fishing	☐ Reading
☐ Biking	☐ Golf	☐ Sewing/arts/crafts
☐ Boating/Water Sports	☐ Home Repairs	☐ Snow Sports
☐ Bookkeeping	☐ Hunting/shooting	☐ Spectator sports
☐ Bowling	☐ Jogging/running	☐ Tennis
☐ Competitive Sports	☐ Landscaping/gardening	☐ Watching TV
☐ Computer	☐ Musical Instrument	☐ Welding/woodworking
☐ Drawing/painting	☐ Motorcycling	☐ Other_____

4. Do your eyes seem bothered by glare from any of the following situations? (Check all that apply)

☐ Car Headlights	☐ Haze	☐ Sunshine
☐ Computer Monitor	☐ Night Driving	☐ Traffic Lights
☐ Fluorescent Lights	☐ Other_____	

5. If you wear contact lenses, do you have? (Check all that apply)

   ☐ Current pair of prescription eyeglasses

   ☐ Current pair of prescription sunglasses

6. Do you have metal and/or latex allergies? ☐ Yes ☐ No

7. Are your lenses scratched or damaged from regular use? ☐ Yes ☐ No

8. Do you spend more than one hour per day in the sun? ☐ Yes ☐ No

9. Are your current glasses uncomfortable? Any fit issues? ☐ Yes ☐ No

10. What improvements do you want to make to your new eyewear? _____

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