***Name:*___________________________________**

PATIENT LIFESTYLE QUESTIONNAIRE

What is your main reason for coming here today?
____
____

Please circle the correct response.

Do you wear eyeglasses ? **Yes No**
If yes: **wear them full time for distance only for near only**
for computer use for sports

Do you experience any of the following discomfort at work or at home?
Headaches Letters blur as you read Occasionally see double
Eyestrain red or watery eyes Pulling sensation near eyes
Get sleepy Lose your place often

Does it take more and more effort to see clearly as the day wears on?
Yes No

Do you avoid reading after work, but read on weekends? **Yes No**

How long can you read? ____________________

Is it ever difficult to bring print or objects to clear focus? **Yes No**

Are there any activities you would enjoy doing, but must restrict because of your vision? **Yes No**
If yes, what?: ____

For parents: Are you concerned about the worsening of your child's/children's prescription? **Yes No**

Corneal Refractive Therapy (CRT) is a contact lens that is worn while sleeping so there is no need for surgery, glasses, or daytime contact lenses. Laservision Eye Care Center physicians are CRT Certified Practitioners. This is approved for all patients ages 6 and over.
Would you be interested in this exciting, safe therapy? **Yes No**

Do you wear contact lenses at this time? **Yes** **No**

If yes, what type? **Soft** **Extended wear** **Disposal** **Hard**
Monovision **Bifocal** **Multifocal**

Have you had problems wearing contacts? **Yes** **No**

Have you been told you cannot wear contacts? **Yes** **No**

Are you interested in trying contacts? **Yes** **No**

OCCUPATION: ______________

Do you use a computer on your job**? Yes** **No** # hours daily______
Do you use a computer at home? **Yes** **No** # hours daily______
Do you often play video/computer games**?** **Yes** **No**
Does office lighting bother you? **Yes** **No**
Do reflections and glare bother you? **Yes** **No**

In what recreational activities do you participate? (*Circle all that apply)*
Reading Racquetball Tennis Golf Baseball Basketball Swimming
Camping Sewing Playing cards Flying Video/Computer games
Musical instrument Scuba diving Skiing Shooting Bicycling

Do you wear any special or protective eyewear for your sport? **Yes** **No**

Does your vision, or do your lenses, interfere with any activity? **Yes** **No**

What are you doing to protect your eyes from ultraviolet exposure?
____

Do you currently wear glasses that have an anti-reflective coating? **Yes** **No**

Is your vision uncomfortable while driving? **Yes** **No**

Does the glare from lights bother you at night? **Yes** **No**

Laser vision correction can be performed as an outpatient , inless than one minute per eye.The procedure performed by our physicians is called "LASEK." Are you interested in a laser procedure which may eliminate your dependency on glasses or contact lenses? **Yes** **No**