Family Eye Care Center & Optical Gallery

Better Vision…Better Life:
A Lifestyle Questionnaire

Please take a moment to answer this brief questionnaire. Your answers will help us assist you in determining the best possible options regarding your eye health. Thank you.

Name: _____ Date: _____

Do you mind wearing glasses? ☐ YES ☐ NO
If YES, why? _____

How many pair(s) of glasses do you own? _____
Please check off each type you own:
☐ Readers ☐ Distance Glasses
☐ Bifocals ☐ Prescription Sunglasses
☐ Progressives ☐ Sports Goggles

Do you wear contact lenses? ☐ YES ☐ NO
If YES, how many hours per day do you wear them? ☐ 6-12 hours ☐ 12-24 hours

Have you ever had an eye infection? ☐ YES ☐ NO

Do you have dry eyes? ☐ YES ☐ NO

Do your eyes get red after wearing your contacts for a while? ☐ YES ☐ NO

Do you use a computer? ☐ YES ☐ NO
If YES, how many hours per day? ☐ 1-3 hours ☐ 4+ hours

Do you participate in any sports or outdoor activities? ☐ YES ☐ NO
☐ Golf ☐ Swimming
☐ Walking/Running ☐ Tennis
☐ Gardening ☐ Fishing/Boating
☐ Skiing/snowboarding ☐ Other _____

What are your hobbies? _____

Do you have problems seeing while driving at night? ☐ YES ☐ NO

Have you ever considered Laser Vision Correction? ☐ YES ☐ NO