BIRCH RUN EYE CARE
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Patient Lifestyle Questionnaire

Name_____Date_____
Occupation_____ Age_____ Sex: Male Female

1. Do you currently wear eyeglasses? (Yes No)
If Yes, do they help with distance vision, near vision, or both?_____

2. Were you planning on getting new glasses today? (Yes No)

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

___ Artificial Lighting
___ Board Work
___ Close-up Work
___ Computer Work
___ Natural Lighting
___ Night Driving
___ Paperwork
___ Potential Eye Hazards
___ Reading
___ Other_____

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

___ Auto Repair
___ Biking
___ Boating/Water Sports
___ Bookkeeping
___ Bowling
___ Competitive Sports
___ Computer
___ Drawing/Painting
___ Fishing
___ Golfing
___ Home Repairs
___ Hunting/Shooting
___ Jogging/Running
___ Landscaping/Gardening
___ Musical Instrument
___ Racquetball
___ Reading
___ Sewing/Arts/Crafts
___ Snow Sports
___ Exercise
___ Tennis
___ Watching TV
___ Welding/Woodwork
___ Other_____

5. Are your eyes bothered by glare from any of the following situations? *(circle all that apply)*

- Car headlights
- Sunshine
- Night driving
- Fluorescent lights
- Other_____
- Fog/Haze
- Computer Monitor
- Traffic lights
- Street lights

6. If you wear contact lenses, do you have?

- Current pair of prescription eyeglasses (Yes No)
- Current pair of polarized sunglasses (Yes No)

7. Are you interested in trying daily contact lenses today for FREE?

8. If you are not a contact lenses wearer, are you interested in contact lenses?

9. Do you wear prescription sunglasses?

10. Are you interested in laser vision correction?

11. Do you have family members in need of eye care?

12. Are you interested in a payment plan for today's services or products?