Spectrum Eye Institute

Name_____ Date_____

Email address _____

LIFESTYLE QUESTIONNAIRE

At Spectrum Eye Institute, we strive to provide the best quality of care and customized vision solutions for our patients. This checklist will assist us in providing the treatment best suited for your visual needs & lifestyle.

1. Does wearing glasses bother or frustrate you? Yes No
2. Are you interested in reducing your need for glasses? Yes No
3. Would it bother you to wear reading glasses after surgery? Yes No
4. Do you do a lot of night driving? Yes No
5. Do you use a computer more than two (2) hours per day? Yes No
6. Do you do close detail work? Yes No
7. Have you ever tried monovision or bifocal contact lenses? Yes No
   a. If yes, did/do you like it? Yes No
8. How important is it for you to be able to see in the distance without glasses after surgery?

   Very important____ Important____ Somewhat important____ Not important____
9. What are your hobbies? _____

   _____

   _____
10. What sports or recreational activities do you engage? _____

    _____

    _____
11. How would you describe your personality?

    ____ Easy going ____ Perfectionist ____ In between