

Lifestyle Questionnaire

Patient Name_____	Age_____	Today's Date_____
Address_____	City, State, ZIP_____	
Home Phone_____	Cell Phone_____	
Occupation/Grade_____	Employer/School_____	
Vision Insurance Co_____	Medical Insurance Co_____	
Name of General Physician_____	Phone #_____	

Do you. . . . (check box if your answer is yes)

- Work at a computer?
- Think you might benefit from thinner, lighter lenses?
- Have interest in a "Test Drive" of the latest contact lens design?
- Spend time outdoors? (How much?) _____ hrs/week
- Have prescription sunglasses?
- Have interest in ordering prescription sunglasses?
- Prefer not to wear your glasses at times?
- Want information on Laser Vision Correction Surgery?
- Have more than one pair of current prescription glasses?
- Have children?
- Have family members in need of Eyecare?

Please check box if you...

- | | |
|---|---|
| <input type="checkbox"/> Are currently pregnant. | <input type="checkbox"/> Have a family member diagnosed with Retinal Detachment. |
| <input type="checkbox"/> Are currently nursing. | <input type="checkbox"/> Have a family member diagnosed with Macular Degeneration. |
| <input type="checkbox"/> Have been diagnosed with Diabetes. | <input type="checkbox"/> Have a family member diagnosed with Glaucoma. |
| <input type="checkbox"/> Have been diagnosed with Macular Degeneration. | |
| <input type="checkbox"/> Have been diagnosed with Glaucoma. | |

List your hobbies/activities:

Thank you

Reviewed:_____

Reviewed:_____

Reviewed:_____

Reviewed:_____

Reviewed:_____

Reviewed:_____