*Lifestyle Questionnaire* *Benefield Eye Care, PC*

**Name:__________________________________ Date:______________________**

**We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle.**

**How important is it for you to see without glasses?**

☐ Very important ☐ Somewhat important ☐ Not important

**How important is it for you to see to read or use the computer without glasses?**

☐ Very important ☐ Important ☐ Not important

**If it were possible to go without glasses for most of the time, would you like that?**

☐ Yes ☐ No

**Do you notice halos / rings around lights at night?**

☐ Yes ☐ No

**Do you use a computer on a daily basis?**

☐ Yes ☐ No

**Circle the number that best describes your personality.**

**1 2 3 4 5 6 7 8 9 10**

**easy going detail-oriented perfectionist**

**Did you know that we have over twenty ways to help you see better without glasses? Ask us which is the best for you.**

**Check the following activities you do on a regular basis:**

- ☐ Read newspaper, books
- ☐ Drive daytime
- ☐ Tennis
- ☐ Musician
- ☐ Photography
- ☐ Read medicine bottles
- ☐ Drive nighttime
- ☐ Hunt or Fish
- ☐ Play cards / Dominos
- ☐ Spectator sports
- ☐ Needlepoint
- ☐ Shop
- ☐ Paint / Artist
- ☐ Cook
- ☐ Golf
- ☐ Movie theatre
- ☐ Wall Street Journal
- ☐ Dine in Restaurant

**Underline the above activities that you would like to see *without glasses if possible***

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

________________________________________

________________________________________

- ________________________________________

**Make sure you ask us if you are a candidate for a refractive procedure (LASIK, Lens Implant or CK) today!**