

# Digby Eye Associates

## Lifestyle Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_ Chart No. \_\_\_\_\_ Tech \_\_\_\_\_

Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what is your job? \_\_\_\_\_

Does your job include working on the computer? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what percentage of your job requires computer work? \_\_\_\_\_

Are there any special vision requirements at work? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what? \_\_\_\_\_

What activities and sports do you engage in? Please check all that apply.

- |  |   |   |
|--|---|---|
| <input type="radio"/> Read newspaper/books | <input type="radio"/> Shop/woodworking        | <input type="radio"/> Playing piano or other instrument |
| <input type="radio"/> Work on the computer | <input type="radio"/> Cooking                 | <input type="radio"/> Bowling                           |
| <input type="radio"/> Golf                 | <input type="radio"/> Tennis                  | <input type="radio"/> Fishing                           |
| <input type="radio"/> Hunting              | <input type="radio"/> Baseball                | <input type="radio"/> Basketball                        |
| <input type="radio"/> Shooting             | <input type="radio"/> Boating                 | <input type="radio"/> Swimming                          |
| <input type="radio"/> Football             | <input type="radio"/> Biking                  | <input type="radio"/> Aerobics                          |
| <input type="radio"/> Running              | <input type="radio"/> Carpentry               | <input type="radio"/> Driving                           |
| <input type="radio"/> Sewing               | <input type="radio"/> Crafts/Drawing/Painting | <input type="radio"/> Bookkeeping                       |
| <input type="radio"/> Playing Cards        | <input type="radio"/> Other _____             |   |

Are you satisfied with your distant, intermediate, and/or reading vision? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, why \_\_\_\_\_

Do you wear sunglasses? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the glare from headlights bother you? Yes \_\_\_\_\_ No \_\_\_\_\_

What visual limitation with or without correction interferes most with your lifestyle? \_\_\_\_\_

### Office Use Only

#### Brochure Given:

- |                                  |     |    |
|----------------------------------|-----|----|
| <input type="radio"/> Restor     | Yes | No |
| <input type="radio"/> Crystalens | Yes | No |
| <input type="radio"/> LASIK      | Yes | No |

- |                                  |     |    |
|----------------------------------|-----|----|
| <input type="radio"/> Visian ICL | Yes | No |
| <input type="radio"/> Rezoom     | Yes | No |