PATIENT LIFESTYLE SUPPLEMENT FOR: _____ (NAME)

Your responses to the following items will help us make the best recommendations for your eyecare we look forward to providing you.

Preferences and Interests

1. If you wear contact lenses, what kind? _____
2. What cleaning solutions do you use? _____
3. Have you ever been interested in color contact lenses? YES NO (circle one)
4. If you don't currently wear contact lenses, have you ever tried them? YES NO
5. Would you be interested in a "test drive" of the latest in contact lens design? YES NO
6. Are you interested in thinner, lighter lenses if you wear glasses? YES NO
7. Do you prefer not to wear your glasses at times? YES NO
8. Would you like information on Laser Vision Correction? YES NO
9. Are you interested in a non-surgical approach to vision correction? YES NO

Current Satisfaction with your Vision

10. If you wear bifocals, are you bothered by the lines or head tilting? YES NO
11. If you wear contacts, are you satisfied with the vision and comfort? YES NO
12. If you wear glasses, are you satisfied with the vision and comfort? YES NO
13. Do you have more than one pair of current prescription glasses? YES NO

Lifestyle Factors

Do you... (circle answer)

- Work a lot at the computer? YES NO
- Spend time outdoors? YES NO
- Have prescription sunglasses? YES NO
- Have 100% UV protection in your sunglasses (whether prescription or not)? YES NO
- Have polarized lenses in your sunglasses (whether prescription or not)? YES NO
- Have children? YES NO
- Have family members in need of eyecare? YES NO
- Have hobbies that strain your eyes? YES NO
- Work around hazardous materials (bio or chemical hazards)? YES NO
- Have an east-west commute? YES NO
- Drive a lot at dusk, dawn, or nighttime? YES NO
- Spend a lot of time in areas with low lighting? YES NO