

**PLEASE COMPLETE PRIOR TO YOUR APPOINTMENT AND GIVE TO TECHNICIAN**

## **LIFESTYLE QUESTIONNAIRE**

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

**Which of the following activities would you be interested in seeing well without glasses?**

- Reading the newspaper
- Reading a prescription medicine bottle
- Looking at your watch
- Working on your computer
- Dialing a phone
- (Ladies) Putting on your make-up
- (Men) Shaving your face

**Other activities you would enjoy without glasses:** \_\_\_\_\_

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**What sporting or recreational activities do you currently engage in?**

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**Would you be interested in paying additional out of pocket expenses (above co-pays and deductibles) for the latest technologies (premium lenses), or are you interested only in what is covered by insurance?** \_\_\_\_\_

**Place an "X" on the following scale to describe your personality as best you can:**

Easygoing

Perfectionist

Patient Signature: \_\_\_\_\_