Columbus Ophthalmology associates

Lifestyle Questionnaire

Name:_____ Date:_____/_____/_____

It is important to make sure your doctor has a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle and preferences.

What is your occupation?_____

What hobbies, sports or other recreational activities do you enjoy?

_____

Please circle the activities you would prefer to do with <u>less dependence on glasses</u>:

Reading books/newspapers	Applying makeup	Watching live sports
Reading medicine labels	Shaving your face	Watching TV
Looking at your watch	Card or table games	Daytime driving
Viewing/dialing cell phone	Using a computer	Nighttime driving
Knitting or needlepoint	Using a handheld tablet device	Playing sports, like golf

Other activities not listed here: _____

Please share anything else you think might be important about your lifestyle or daily activities:

_____

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

_____

Easygoing Perfectionist

Patient Signature:_____