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Grass Valley CA 95945
(530) 273-4451

Name: _____

Patient Lifestyle Questionnaire

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us to better understand your vision care needs. Please check all that apply.

Please bring your glasses / contact lenses and contact lens solutions with you to your appointment.

___ I work in a professional business office.
___ I work from home.
___ I am a student.
___ I work outside most of the time.
___ My job requires travel. (driving / flying / both)
___ I am retired.

How much time do you spend each day on a computer?
___0 - 1 Hours ___3 - 5 Hours
___1 - 3 Hours ___5 + Hours

How far away do you sit from your computer monitor? _____ inches

What type of outdoor activities do you participate in? (check all that apply)

___ Golf	___ Gardening	___ Skiing
___ Team Sports	___ Boating	___ Hiking
___ Jogging/Walking	___ Biking	___ Other

What are your indoor hobbies?

___ Reading	___ Sewing / Knitting
___ Music	___ Painting / Drawing
___ Crafting	___ Other

What did you like about your last pair of glasses? _____
_____

What would you change? _____
_____

Do you wear your glasses all day? ____ *yes* ____*no*

Do you experience difficulty with nighttime vision, ie; glare when driving ____ *yes* ____ *no*

Are you constantly going in and out of sunlight throughout the day? ____ *yes* ____ *no*

Are you experiencing eyestrain, vision fatigue or headaches? ____ *yes* ____ *no*

Are you interested in wearing contact lenses? ____ *yes* ____ *no*

If you have any questions please call 530-273-4451 or email eyecare@drchristensen.net