Spectrum Eye Institute

Lifestyle Questionnaire

Name: _____ **Date:** _____

Do you use Digital Devices Frequently?

☐No ☐Yes

What Devices do you use?

☐Cell Phone ☐Tablet ☐Laptop Computer ☐Desktop Computer ☐ Other_____

How do you like to read?

☐Books ☐Newspaper ☐Magazines ☐Digital Devices ☐Other _____

Do you drive?

☐Often ☐Sometimes ☐Never

Do you drive at night?

☐Often ☐Sometimes ☐Never

Have you been diagnosed with other vision conditions?

☐No ☐Yes _____

Have you had eye surgery in the past?

☐No ☐Yes _____

How do you feel about glasses?

☐Love them ☐Don't mind them sometimes ☐Can't stand them

Have you ever worn contact lenses?

☐No ☐Yes, if so what type of contacts _____

How would you rate your personality?

☐Perfectionist ☐In-between ☐Easygoing

What are your hobbies?

_____