PATIENT LIFESTYLE SUPPLEMENT

Preferences and Interests:

If you wear contact lenses, what kind? _____

What cleaning solutions do you use? _____

Have you ever been interested in colored contact lenses? _____

If you don't currently wear contact lenses, have you ever tried them?	YES	NO
Would you be interested in a "test drive" of the latest in contact lens design?	YES	NO
Are you interest in thinner, lighter lenses if you wear glasses?	YES	NO
Do you prefer not to wear your glasses at times?	YES	NO
Would you like information on Laser Vision Correction?	YES	NO
Are you interested in a non-surgical approach to vision correction?	YES	NO

Current Satisfaction with your vision:

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

Lifestyle Factors:

Do You… (Check box if answer is yes):

[ ] Work a lot at a computer?
[ ] Spend time outdoors? How much? _____ hrs/wk
[ ] Have prescription sunglasses?
[ ] Have 100% UV protection in you sunglasses (whether prescription or not)?
[ ] Have polarized lenses in your sunglasses (whether prescription or not)?
[ ] Have children?
[ ] Have family members in need of eye care?
[ ] Have hobbies that strain your eyes?
[ ] Work in a hazardous environment such as manufacturing?
[ ] Work around hazardous materials (bio or chemical hazards)?
[ ] Have an east-west commute?
[ ] Drive a lot at dusk, dawn or nighttime?
[ ] Spend a lot of time in areas with low lighting?

Are there any other lifestyle factors that may be affecting your vision?

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