Munster Eye Care Associates. P.C.

Vision Lifestyle Questionnaire

Our mission at Munster Eye Associates, P.C. is to provide you with the highest quality and personalized eyecare. Please tell us more about you so we can make the best possible eyewear recommendations. Thank you for completing this survey.

1) **Are you currently:** (circle all that apply)
   Retired   Homemaker   Student   Employed: Occupation ___________ ___________
   Are you required to wear safety glasses? Yes/No

2) **During an average day, how many hours do you spend reading or doing close work? _____ hrs Computer ______ hrs**

3) **How far is the reading or close work material from you?** (circle all that apply)
   12-14 inches (holding a book/ sheet of paper)   24 inches (arms length)   more than 24 in but less than 20 ft

4) **How wide is the reading material or close work?** (circle all that apply)
   standard page (8 1/2 X 11)   newspaper width   blueprint width

5) **How would you describe the lighting at your personal work area?**
   low   adequate   bright   contrast   glare

6) **Are you bothered by the glare of the sun during the day or at sunrise/sunset?** Yes/No

   Are you aware of halos around or glare from oncoming headlights or streetlights at night? Yes/No

7) **Does your work or after work activities cause you to go from indoors to outdoors frequently?** Yes/No

8) **Have you ever felt your eyeglass lenses were:** (circle all that apply)
   Too Thick?   Made your eyes look larger?   Too heavy?   Made your eyes look smaller?

9) **What do you like most about your present glasses?**   **Least?**

10) **Have you ever wished you could see clearly without eyeglasses?** Yes/No   **Contact lenses?** Yes/No

11) **What activities, sports or hobbies do you engage in?**

Recommendations:

Glasses assessment: adjustment   change nose pads   new frame   thinner lenses   AR   polarized sunglasses   reading glasses

Medical Condition Affecting Vision: Cataracts, ARMD, Sicca, Strabismus, Amblyopia, Diabetes, Glaucoma

Patient's name ____________________________________ Account # _________________

Techncian:______ _______ _______ _________________ Date ____________________

office protocol: technicians - complete with patient, doctors - make recommendations, opticians – make recommendations/order
Fill out for all patients that need a refraction. Verify annually at refraction time or as information changes.

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