JANET M. MINT, O.D. • 4131 Southside Blvd., #203 Jacksonville, FL 32216 • 904-646-9737

Patient Name: _____ Date: _____

Lifestyle Questionnaire

Your answers will assist us in providing appropriate product recommendations to meet your specific personal eye care needs.

YES	NO		YES	NO	
◯	◯	Seasonal allergies affect your eyes	◯	◯	Participate in sports or exercise
◯	◯	Drive during daylight hours	◯	◯	Reading for work/ school/personal
◯	◯	Regularly spend time in the sun	◯	◯	Use digital devices ___hrs/day (Computers, cellphones and/or tablet)
◯	◯	Wear sunglasses/ transitions	◯	◯	Travel often; have trips scheduled

List all sports, hobbies or activities outside of work or school

_____

What do you like about your current eyeglasses?

_____

What do you dislike about your current eyeglasses?

_____

If you do not currently wear contact lenses:

YES NO

◯ ◯ Have you ever been fit or tried contact lenses?
If YES, when was the last fit? _____

If YES, why did you discontinue wear? _____

◯ ◯ Are you interested in contact lenses now?

◯ ◯ Are you interested in the convenience of a daily- disposable contact lens for only occasional wear for sports or social events?