

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**

- Seasonal allergies affect your eyes
- Drive during daylight hours
- Regularly spend time in the sun
- Wear sunglasses/ transitions

**YES NO**

- Participate in sports or exercise
- Reading for work/ school/personal
- Use digital devices \_\_\_hrs/day  
(Computers, cellphones and/or tablet)
- Travel often; have trips scheduled

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

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What do you like about your current eyeglasses?

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What do you dislike about your current eyeglasses?

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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?