MOYES EYE CENTER
Joy Through Sight

Lifestyle Questionnaire

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?

Reading small print, pill bottles, newspaper, books or the telephone book?	Yes	No
Reading traffic signs, street signs or store signs?	Yes	No
Doing fine handwork like sewing, knitting or carpentry?	Yes	No

Other specific visual task concerns: _____

Symptoms

Have you been bothered by:

Poor night vision, color vision or double vision?	Yes	No
Hazy and/or blurry vision?	Yes	No
Seeing in poor or dim light?	Yes	No
Seeing rings or halos around lights at night while driving?	Yes	No
Glare caused by headlights or bright sunlight?	Yes	No
Do you do a lot of night driving?	Yes	No
Do you have dry eyes?	Yes	No
Do your eyes water a lot?	Yes	No

Lifestyle Considerations

What is or was your occupation? _____

Do you use the computer frequently?	Yes	No
Do you do a lot of close detailed work?	Yes	No
Do you like wearing glasses to correct your vision?	Yes	No
Do you wear progressive or no-line bifocals?	Yes	No
Do you take your glasses off to read or do fine work?	Yes	No
Have you had previous refractive surgery (LASIK, PRK, RK)?	Yes	No
Do you wear contact lenses?	Yes	No

If so did/do you wear:

☐ Distance contacts with readers ☐ Monovision contacts ☐ Multifocal contacts

Your Goals for surgery

I want to improve my vision and I:

- ☐ would be happy to wear glasses all the time to fine tune my vision
- ☐ would like to have good distance vision without glasses and wear glasses for computer and reading
- ☐ would like to have good near vision without glasses and wear glasses for distance viewing
- ☐ would like to have good distance and near vision without glasses and rely on minimial glasses