Lifestyle Questionnaire

Benefield EYE CARE

Name:_____ Date:_____

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis.

Along with your eye exam, this info will assist us in recommending the best options for your eyes andyour personal lifestyle.

How important is it for you to see without glasses?

- ☐ Very Important
- ☐ Somewhat important
- ☐ Not important

How important is it for you to see to read or use the computer without glasses?

- ☐ Very important
- ☐ Somewhat important
- ☐ Not important

If it were possible to go without glasses for most of the time, would you like that?

- ☐ Yes
- ☐ No

Do you notice halos / rings around lights at night?

- ☐ Yes
- ☐ No

Do you use a computer on a daily basis?

- ☐ Yes
- ☐ No

Circle the number that best describes your personality.

1	2	3	4	5	6	7	8	9	10
Easy going				detail oriented				perfectionist	

Did you know that we have over twenty ways to help you see better without glasses? Ask us which is the best for you.

Check the following activities you do on a regular basis:

- ☐ Read newspaper, books
- ☐ Drive during the daytime
- ☐ Tennis
- ☐ Musician
- ☐ Photography
- ☐ Read medicine bottles
- ☐ Drive during the nighttime
- ☐ Hunt or fish
- ☐ Play cards/ Dominos
- ☐ Spectator sports
- ☐ Needlepoint
- ☐ Shop
- ☐ Paint/ Artist
- ☐ Cook
- ☐ Golf
- ☐ Movie theatre
- ☐ Wall Street Journal
- ☐ Dine in Restaurant

Underline the above activities that you would like to see without glasses if possible.

What occupational, recreational, or other activities do you currently engage in that are not listed above?

_____

_____

_____

Make sure you ask us if you are a candidate for a refractive procedure (LASIK, Refractive Lens Exchange, or Implantable Contact Lens) today!

CHECK ALL THAT APPLY:

- ☐ I have double vision
- ☐ I have glare
- ☐ Lights bother me at night
- ☐ Lights bother me during the day
- ☐ My vision is blurry
- ☐ I have difficulty reading
- ☐ I have difficulty seeing road signs
- ☐ I can't see to function like I would like to
- ☐ I would like to see better
- ☐ Difficulty getting driver's license
- ☐ Problems safely navigating/walking

List a few things that you do on a regular basis that are blurry and cause problems for you:

_____

_____

Example: Driving, T.V., sewing, computer, playing cards, bird watching, cooking, hunting or fishing. (may also circle all that apply)

Difficulty: ☐ **Mild** ☐ **Moderate** ☐ **Extreme**

The problem began ____months, years or decades ago? (circle one)

Signature: _____ **Date:** _____

Patient Name:_____ Practice: BENEFIELD EYE CARE,PC

Survery Date:_____ Operating Physician: _____

PRE-CATARACT SURGERY – VISUAL FUNCTIONING INDEX (VF-8R) PATIENT QUESTIONNAIRE

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

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
3. Seeing steps, stairs or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
4. Reading traffic signs, street signs or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity

Patient Signature_____ Date_____

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