

# Chili Vision Group Lifestyle Questionnaire

This questionnaire will assist your eye care professional in choosing eye wear that best fits your lifestyle and activities.

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

1. How often do you wear your glasses?

- All the time
- Never
- Mostly for reading
- Mostly when working on the computer
- Mostly for driving and to see at a distance
- Mostly to watch TV
- Only when I don't wear my contacts

2. Do you participate in potentially hazardous activities for your eyes, such as hunting, golfing, woodworking, use of chemicals, etc.?

- Yes
- No

3. Do you typically experience any of the following?

- Night driving fatigue or discomfort
- Glare from headlights or street lights
- Visual discomfort or blinding from sunlight glare
- Other \_\_\_\_\_

4. How do you use your vision at work or school?

- On the computer
- For close up vision
- For intermediate vision
- For distance vision
- A balance mix of all the above
- Other \_\_\_\_\_

5. What do you enjoy doing in your spare time?

- Boating/fishing/water sports
- Golf
- Tennis
- Gardening
- Hunting
- Reading
- Computer
- Card, board games
- Craft/sewing/knitting
- Manual work/handy work
- Other \_\_\_\_\_

6. Do you currently use more than one pair of glasses?

- Yes
- No

7. If so, how do you use your multiple pairs?

- Hobby/spare time activity
- Sports
- When Driving
- As prescription sunglasses
- As plano sunglasses over contacts
- As occupational glasses
- Reading glasses
- Casual glasses
- Dress up glasses
- Back up glasses
- Other \_\_\_\_\_

8. Do you spend a lot of time in bright sunlight?

- Yes
- No

9. Do you wear sunglasses?

- Yes
- No

10. Would you like your lenses to be thinner than your present pair?

- Yes
- No

11. Do you wear contacts?

- Yes
- No

12. Are you interested in contacts?

- Yes
- No

13. Are you interested in LASIK (Refractive Eye Surgery)

- Yes
- No