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LIFESTYLE QUESTIONNAIRE

Please help us get to know you better.

Name: _____

Date: _____

What is your occupation (present or former)? _____

Which of the following activities are especially important for you to see well without glasses?

- | | |
|--|---|
| <input type="checkbox"/> Reading the paper | <input type="checkbox"/> Working on your computer |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Reading road signs |
| <input type="checkbox"/> Looking at your watch | <input type="checkbox"/> Seeing the dashboard in your car |
| <input type="checkbox"/> Shaving your face (men) | <input type="checkbox"/> Applying makeup (women) |

Other activities you would like to enjoy without glasses: _____

What recreational activities do you enjoy? _____

Please tell us about any vision concerns not addressed above. _____

Place an "X" on the following scale to describe your personality as best you can:

EASY GOING ←————→ **PERFECTIONIST**

Patient Signature

Chart No: _____