

Lifestyle Questionnaire

Are you thinking about new glasses? Take a moment to think about your vision needs so that we can best assist you in choosing the eyewear that's right for you. Simply print it out, fill it out, and bring it with you when you come to Brevier Optical.

1. Which of the following visual demands do you encounter on a regular basis? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> artificial lighting | <input type="checkbox"/> meetings/presentations | <input type="checkbox"/> computer work |
| <input type="checkbox"/> potential eye hazards | <input type="checkbox"/> paperwork | <input type="checkbox"/> lecture halls |
| <input type="checkbox"/> reading | <input type="checkbox"/> driving | <input type="checkbox"/> other: _____ |

2. Which of the following hobbies or activities do you participate in?

- | | | |
|---|--|---|
| <input type="checkbox"/> auto repair | <input type="checkbox"/> woodworking | <input type="checkbox"/> gardening/landscaping |
| <input type="checkbox"/> painting | <input type="checkbox"/> crafts | <input type="checkbox"/> sewing/knitting |
| <input type="checkbox"/> reading | <input type="checkbox"/> drawing | <input type="checkbox"/> home repairs |
| <input type="checkbox"/> watching TV/movies | <input type="checkbox"/> computer | <input type="checkbox"/> welding |
| <input type="checkbox"/> video games | <input type="checkbox"/> musical instrument | <input type="checkbox"/> driving |
| <input type="checkbox"/> boating or watersports | <input type="checkbox"/> hunting/shooting | <input type="checkbox"/> jogging/running |
| <input type="checkbox"/> biking | <input type="checkbox"/> golf | <input type="checkbox"/> fishing |
| <input type="checkbox"/> spectator sports | <input type="checkbox"/> racquetball | <input type="checkbox"/> tennis |
| <input type="checkbox"/> working out | <input type="checkbox"/> skiing/snowboarding | <input type="checkbox"/> recreational sports: _____ |
| <input type="checkbox"/> other _____ | | |

3. Do your eyes seem bothered by glare in any of the following situations:

- | | | |
|---|--|--|
| <input type="checkbox"/> car headlights | <input type="checkbox"/> hazy conditions | <input type="checkbox"/> snow |
| <input type="checkbox"/> computer monitor | <input type="checkbox"/> night driving | <input type="checkbox"/> overhead lighting |
| <input type="checkbox"/> fluorescent lighting | <input type="checkbox"/> bright sunshine | <input type="checkbox"/> other: _____ |

4. If you wear contacts, do you have:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> current prescription eyeglasses | <input type="checkbox"/> sunglasses | <input type="checkbox"/> glasses that are worn over the contacts |
| <input type="checkbox"/> other _____ | | |

5. Are you aware of any metal or silicon allergies?

- | | |
|-------------------------------------|-----------------------------|
| <input type="checkbox"/> yes: _____ | <input type="checkbox"/> no |
|-------------------------------------|-----------------------------|

6. What do you like about your current glasses or contacts? (color/fit/style, etc?) _____

7. If there was anything you would change about your glasses, what would it be (weight/thickness/glare, etc?) _____
