LIFESTYLE QUESTIONNAIRE

Patient Name ______________________________ Patient DOB __________

Email Address ______________________________

Present or Past Occupation ______________________________

Have You Previously Been Seen by Dr. Carter? ◯ Yes ◯ No

How Did You Hear About Carter Eye Center? ______________________________

Who Did You Bring with You Today? ______________________________

Have Any of Your Family Members Ever Had Surgery with Carter Eye Center? ◯ Yes ◯ No

If Yes, What Kind of Surgery? ______________________________

Do You Wear Contacts? ◯ Yes ◯ No If Yes: ◯ Soft ◯ Toric ◯ RGP Date Last Worn __________

Do You Have Prism in Your Glasses? ◯ Yes ◯ No

Do You Experience Double Vision? ◯ Yes ◯ No

I Struggle with the Following Activities With or Without Glasses:

- ◯ Reading Fine Print
- ◯ Driving in Daytime
- ◯ Watching TV
- ◯ Reading Traffic Signs
- ◯ Playing Golf
- ◯ Driving at Night/Evening
- ◯ Doing Computer Work

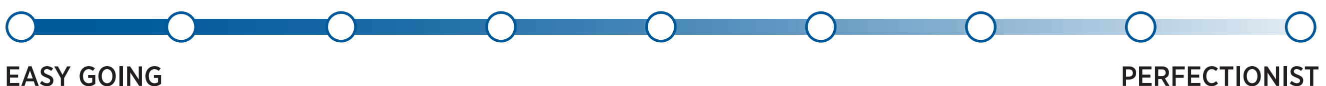
I Currently Have Problems With:

- ◯ Glare/Halos
- ◯ Hazy/Blurry Vision
- ◯ Blurred Vision
- ◯ Seeing in Poor/Dim Lighting

My Hobbies Include:

- ◯ Crafts/Sewing/Painting
- ◯ Piano/Music
- ◯ Sports
- ◯ Computer/Tablet
- ◯ Reading
- ◯ Shooting/Hunting
- ◯ Boating/Fishing
- ◯ Swimming/Water Activities
- ◯ Golf

Fill in the Circle on the Scale Below that Would Best Describe Your Personality.



EASY GOING **PERFECTIONIST**