INSIGHT VISION GROUP

Name:____ Date: ___________________________

LIFESTYLE Questionnaire:

1. What is your occupation? ____

2. What are your favorite hobbies? ____

3. Do you do a lot of close detail work such as: sewing/knitting/drawing/etc.? ☐ Yes ☐ No

4. How do you feel about wearing glasses? (please check all that apply)
   - ______ I don't mind wearing glasses all day.
   - ______ I don't mind wearing glasses for reading/close work.
   - ______ I don't mind wearing glasses for TV/driving distances.
   - ______ I would like to greatly reduce dependence on glasses for both reading and far distance.

5. Have you ever tried monovision with contact lenses/glasses? ☐ Yes ☐ No

6. Does your vision effect your ability to read or perform computer work? ☐ Yes ☐ No

7. Would you be content knowing you may require glasses for some tasks? ☐ Yes ☐ No

8. Do you consider yourself to be an easy-going person and adaptable to change? ☐ Yes ☐ No

9. How did you hear about us?
   - _____ Eye Doctor ______________________________
   - _____ Internet
   - _____ Friend/Family Member ______________________________
   - _____ Saw our signage

10. Do you have an email you would like to share with us? ☐ Yes ☐ No

    If Yes, please provide:______________________________________

~Do you have vision insurance?.~ ☐ Yes ☐ No

If yes, please provide:______________________________