NEW EYES

_____ _____

Patient Name Date

Lifestyle Vision Survey

What **problems** are you having with your **DISTANCE** vision? YES NO

1. I have blurry or distorted vision. ☐ ☐
2. I have double vision. ☐ ☐
3. I have problems with glare, halos, or light sensitivity. ☐ ☐
4. I have a problem driving and seeing clearly the street signs ahead. ☐ ☐
5. I have a problem driving at night due to glare from oncoming headlights. ☐ ☐
6. I have a problem seeing the ball when I play golf or tennis. ☐ ☐
7. I have a problem seeing subtitles, captions, scores or letters on the television. ☐ ☐
8. I have a problem seeing to do _____

What **problems** are you having with your **INTERMEDIATE** vision? YES NO

1. I have a problem reading my computer screen clearly. ☐ ☐
2. I have a problem seeing cards when I am playing board games. ☐ ☐
3. I have a problem seeing my vehicle's instrument panel. ☐ ☐
4. I have a problem seeing menu at the restaurant. ☐ ☐
5. I have a problem seeing items on a shelf in a store. ☐ ☐
6. I have a problem seeing to do _____

What **problems** are you having with your **NEAR** vision? YES NO

1. I have a problem with depth perception. ☐ ☐
2. I have a problem reading books, newspapers or magazines. ☐ ☐
3. I have a problem seeing to do small crafts such as woodwork or knitting. ☐ ☐
4. I have a problem seeing to write letters, checks, forms, bills etc. ☐ ☐
5. I have a problem seeing to do _____

In the future, IF POSSIBLE, I would like to see:

☐ DISTANCE without glasses or contact lenses and wear correction for NEAR
☐ INTERMEDIATE or NEAR without glasses or contact lenses and wear correction for DISTANCE
☐ BOTH DISTANCE and NEAR without glasses or contact lenses
☐ I do not mind wearing glasses or contact lenses for DISTANCE and/or NEAR

OCCUPATION (if retired, before retirement) _____

HOBBY or favorite FREE TIME ACTIVITY _____

_____ _____

Patient Signature Date