WESTERN SLOPE EYE CARE, PLLC

BOOKCLIFF VISION CENTER **SAN JUAN EYE CENTERS**

LIFESTYLE QUESTIONNAIRE

Please complete this brief questionnaire so that we may better identify your needs and provide you with the very best solutions for your eye and vision health.

Circle the most appropriate number on a scale where:
0=never, 1=rarely, 2=occasionally, 3=often, and 4=most of the time

I experience the following eye symptoms:

Dryness	0	1	2	3	4	
Itching	0	1	2	3	4	
Burning/stinging	0	1	2	3	4	
Gritty/scratchy sensation	0	1	2	3	4	
Watering/tearing	0	1	2	3	4	
Blur improved w/ blinking	0	1	2	3	4	
I'm bothered by glare at night	0	1	2	3	4	
I feel eye strain	0	1	2	3	4	
I use non-prescription eyedrops	0	1	2	3	4	
I'm happy with my contacts	0	1	2	3	4	N.A.
I sleep in my contacts	0	1	2	3	4	N.A.

I'd like better protective sunwear YES NO

I wear eye protection playing ball sports YES NO N.A.

I wear protective eyewear while working around toxic substances (e.g. bleach) or around high velocity particles (e.g. grinding, weed-eating):
YES NO N.A.

List any work, hobbies, or outdoor recreational activities with specific vision or eyewear needs:

What would you most like to improve about your vision or vision-wear?