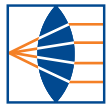

GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

MR#________________

Vision Lifestyle Inquiry

See every moment.®

We are interested in learning how you use your eyes daily. Please indicate the activities that you perform most often. This information will help us determine the best options for you. (circle all that apply)

Zone 1	Zone 2	Zone 3	Zone 4
Far	**Intermediate**	**Near**	**Very Near**
Television	Computer	Newsprint	Tying a fly
Night driving	Cooking	Phonebook	Embroidery
Road signs	Grocery shelf	Maps	Knitting by hand
Movies	iPad	Sewing	
Golf			
Other:	Other:	Other:	Other:

1. Do you like wearing your glasses? _____ Yes _____ No

2. If you work, what are some of your daily work-related tasks?

____

____

3. How much time per day do you spend using electronic devices and reading? (iPad, cell phone, computer, etc.)

____

4. Does your work or livelihood require night-time driving? ______Yes ______ No

5. What recreational or sporting activities are you currently engaged in?

____

____

6. If you need glasses after surgery (always a possibility), for which one activity would you be most willing to wear glasses? (circle one)

   Reading   Computer Work   Driving

7. Questions for your surgeon:

____

____

Scanned to chart ________________
Date