



Visual Lifestyle Review

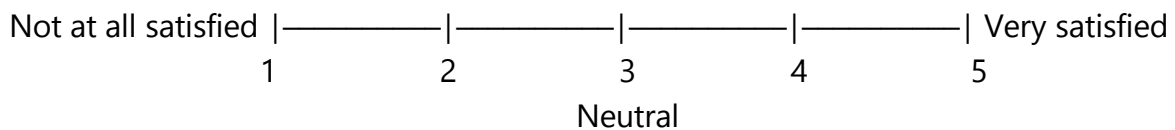
Patient Name: _____

Date of Birth: _____

Date: _____

Please complete this brief questionnaire to help your doctor better understand your visual needs and daily near-vision demands.

1. How satisfied are you with your near vision?



2. What is your occupation? _____

3. Which hobbies or recreational activities do you participate in regularly? (Select all that apply)

- Reading Cooking/Baking Crafts/Sewing Outdoor sports Shooting/Hunting
 Fishing Gardening/Yard work Card/Board games Traveling Computer use/Gaming
 Other: _____

4. How many hours per day do you spend near visual tasks (arm's length and closer)?

- 0–2 2–4 4–6 6–8 8–10 10–12 12+

5. How many days per week do you drive in the dark?

- 0 days 1–3 days 3–5 days 5–7 days

Do you experience glare or halos from lights? Yes No Sometimes

6. If you are deemed a candidate, are you interested in using an eye drop as needed to help improve your near vision?

- Yes No Maybe / I would like more information