ARBOR
CENTERS FOR EYECARE

Patient Lifestyle Questionnaire

NAME: _____

DATE OF BIRTH _____/_____/_____TODAYS DATE:____/_____/_____

Are you interested in Laser cataract surgery? _____Yes _____No

How important would it be for you to be less dependent on glasses for your daily activities?

_____Very important _____Important _____Somewhat important _____Not important

What fine detail, near vision, activities do you enjoy or perform often?

	Carpentry		Painting/other art
	Cooking		Piano/organ/music
	Driving		Playing cards
	Gardening		Puzzles (crossword, general, etc.)
	Needle point/knitting/crocheting		Reading
	Use of cell phone		Other:

What general activities do you enjoy often?

	Biking		Fishing		Traveling
	Bowling		Hunting		Watching TV
	Computer Work		Shopping		Writing
	Golfing		Swimming		Tennis
	Other:				

Please tell us about any other quality of life vision concerns that you have:

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