Lifestyle Questionnaire

Alcon A Novartis Division

Name: _____ **Date:** ____/____/____

It is important to make sure your doctor has a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle and preferences.

What is your occupation? _____

What hobbies, sports or other recreational activities do you enjoy?

_____

Please circle the activities you would prefer to do with less dependence on glasses:

Reading books/newspapers	Applying makeup	Watching live sports
Reading medicine labels	Shaving your face	Playing sports, like golf
Looking at your watch	Card or table games	Watching TV
Viewing/dialing cell phone	Using a computer	Daytime driving
Knitting or needlepoint	Using a handheld tablet device	Nighttime driving

Other activities not listed here: _____

Please share anything else you think might be important about your lifestyle or daily activities:

_____

Patient signature: _____

Staff initials: _____ **Physician initials:** _____

The Apex Approach

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