



Lifestyle Checklist

NAME _____

YES

NO

Do your glasses or contacts often prevent you from enjoying everyday living?

Would you be satisfied if your natural vision was greatly improved even if you still had to wear corrective lenses some of the time?

Do you fear that you would be totally disabled if you lost/misplaced your glasses or contact lenses?

Do you feel that your appearance is better without glasses?

Do your glasses or contacts interfere with your recreational activities?

If yes, which activities: _____

Do you consider yourself to be an easy-going person and adaptable to change?

Do you feel that good vision without glasses is more important to you than perfect vision with glasses?

Is it acceptable to you that you may need glasses for reading after LASIK?

Do you have vision problems with reading or computer work?

If yes, please describe: _____

Do you have vision issues, limitation, or restrictions with your work or profession?

If yes, please describe: _____

Have you had a chance to view our 3 minute informational video on line?

If so, comments: _____

Do you have an e-mail address you would like to share with us?

If yes, please provide: _____