OMEG
Oklahoma Medical Eye Group

Patient Name: _____

Patient DOB: _____

Lifestyle Questionnaire

RIGHT EYE

Check the box that describes your current vision difficulties:	N/A	NONE	A LITTLE DIFFICULT	DIFFICULT EVERYDAY	UNABLE
Reading small print on medicine bottles, books, recipes or food labels.	☐	☐	☐	☐	☐
Reading large printed newspaper headings or books with large font.	☐	☐	☐	☐	☐
Recognizing faces across the same room.	☐	☐	☐	☐	☐
Seeing steps, stairs or curbs in day light or dim light.	☐	☐	☐	☐	☐
Seeing street signs, traffic signs or addresses on buildings.	☐	☐	☐	☐	☐
Watching TV, reading the forecast, reading the ticker across the bottom of the screen, etc.	☐	☐	☐	☐	☐
Driving at night or in low light; glare from oncoming headlights or halos around streetlights.	☐	☐	☐	☐	☐
Driving during a sunny day.	☐	☐	☐	☐	☐
Leisure activities such as shopping, golf, sewing, knitting or sightseeing.	☐	☐	☐	☐	☐

Patient Signature: ______________________________ Date: ____________