Lifestyle Questions:

Name:_____Date:_____

This survey is meant to help the doctor understand what you're experiencing on a regular basis- whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? **Circle one**:

Headaches	-You get headaches of any severity each week (even just a dull ache counts). -Your headaches tend to get worse later in the day. -Your headaches are generally worse at work than they are at home or on weekends	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Stiffness/ pain in neck/ Shoulders	-Your neck gets stiff and sore when you work at a computer or read (This might even be from your posture). -You experience frequent tension in your head, neck or shoulders. -You get frequent massages/ chiropractic adjustments.	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Discomfort with Computer Use	-You feel like you are more productive at work in the morning vs. the afternoon. -Your eyes get tired, burn, or get red easily when you work at computer for long hours.	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Tired Eyes	-Your eyes feel fatigued/tired at the end of a workday. -Your eyes generally feel better in the morning compared to the end of the day.	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Dry Eye Sensation	-Your eyes and/or contacts tend to dry out when you are working at a computer or reading. -Your eyes progressively feel more dry/sandy/gritty as the day goes on.	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Light Sensitivity	-Driving at night is difficult because of glare from headlights. -Fluorescent lights bother you in large spaces (grocery store, department store, etc).	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Dizziness	-Riding in a car gives you motion sickness. -You sometimes feel a sensation of vertigo or disconnectedness from your environment.	1Never	2 Rarely	3 Sometimes	4 Very Often	5 Always

Do you wear glasses?	□Yes	□No
Do you have back-up glasses?	□Yes	□No
Do you have sunglasses?	□Yes	□No
Do you spend a lot of time outdoors?	□Yes	□No
Do you work on electronic devices(phone/tablet/comp) for long periods?	□Yes	□No If so how many hours?_____
Do you have computer glasses?	□Yes	□No
Are you rough on your glasses?	□Yes	□No
Would you benefit from thinner, lighter lenses?	□Yes	□No

List the sports/ hobbies you participate in:_____

Any additional concerns/questions about these symptoms: _____

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