FOR PATIENT USE

FOR OFFICE USE

PT. INITIALS / ID

DATE

Lifestyle Index

This questionnaire is meant to help your 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? Fill in applicable circle. For example: 1 2 3 4 5 (3 selected)

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.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Number of hours per day using a digital device: _____

Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Light Sensitivity

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Dizziness

You experience dizziness, motion sickness, or vertigo.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Additional Notes

Any additional notes you'd like to add: _____

_____