FOR PATIENT USE

Lifestyle Index

FOR OFFICE USE

PT INITIALS / ID _____

DATE _____

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
○	○	○	○	○

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
○	○	○	○	○

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
○	○	○	○	○

Tired Eyes

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

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

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
○	○	○	○	○

Light Sensitivity

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

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

Dizziness

You experience dizziness, motion sickness, or vertigo.

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

Additional Notes

Any additional notes you'd like to add: _____