Lifestyle Questionnaire

How many hours do you spend each day on a computer? ________________

What is your profession? ____

What are your hobbies? ____

Do you currently have sunglasses? ❑ Yes ❑ No

Do you currently have computer glasses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in LASIK? ❑ Yes ❑ No

Please rate the following on a scale from 1-5 with 1 being never and 5 being always:

Headaches (of any severity, usually getting worse later in the day)

1 2 3 4 5

Stiffness/pain in neck/shoulders (when working at a computer or reading)

1 2 3 4 5

Discomfort with computer use

1 2 3 4 5

Tired eyes (increasing throughout the day)

1 2 3 4 5

Dry Eye Sensation (worse on computer or reading)

1 2 3 4 5

Light Sensitivity (especially with stronger lights like headlights or fluorescents)

1 2 3 4 5

Dizziness (experience motion sickness or vertigo)

1 2 3 4 5

Please circle if your eyes experience the following:

Dry Eyes Redness Burning Excessive Tearing Foreign Body Sensation

Contact Lens Discomfort Stringy Mucous Fluctuating Vision

Would you like a complimentary anti-aging assessment? ❑ Yes ❑ No

Are you interested in Botox? ❑ Yes ❑ No