



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 be interested in reducing fine lines and wrinkles around your eyes

while reducing dry eye symptoms? Yes No