

# Lifestyle Index

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



## 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 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## 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 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Discomfort with Computer Use

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

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Tired Eyes

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

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Dry Eye Sensation

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

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Light Sensitivity

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

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Dizziness

You experience dizziness, motion sickness, or vertigo.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Additional Notes

Any additional notes you'd like to add: \_\_\_\_\_