

# 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

of any severity each week, usually getting worse later in the day

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always



## Stiffness / pain in neck / shoulders

when you work at a computer or read

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always



## Discomfort with Computer Use

in your eyes (redness, burning) after long hours looking at the screen

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always



## Tired Eyes

with increasing feeling of eye fatigue throughout the day

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always



## Dry Eye Sensation

feeling progressively more gritty/sandy while working at computer or reading

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always



## Light Sensitivity

especially with brighter, stronger lights like fluorescents or headlights

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always



## Dizziness

or an experience like motion sickness or vertigo

1 Never  2 Rarely  3 Sometimes  4 Very Often  5 Always

## FOR OFFICE USE

Neurolens Value

Prism Split for Order Entry

OD:

OS:

Misalignment

Near:

Distance:

Mono PD

OD:

OS:

MQI

Near:

Distance:

AC/A Ratio