

Computer VisionCareSM

Questionnaire

Please take a moment to complete this questionnaire.

Once completed, take it to your VSP doctor. Your doctor will then be more familiar with your work environment and better able to determine if you are at risk of developing Computer Vision Syndrome, or if you'll need special computer glasses.

General Information

1. Time spent at computer monitor:
_____ hours per day.
2. Work is performed while: (Please describe)

Sitting

Other

3. Lighting in work area: (Please describe, including type of lighting)

4. Are you experiencing any of the following symptoms while at your computer monitor?

Check where appropriate

- Headaches
- Sore or tired eyes (eye strain)
- Blurred near vision
- Glare (light) sensitivity
- Blurred distant vision
- Dry or watery eyes
- Slowness in focusing
- Burning, itching or red eyes (distant to near and back)
- Back pain
- Neck and shoulder pain
- Double vision

5. Do you wear glasses while working at the computer? Yes No
(If yes, please bring them with you to your eye exam)
6. Do you wear contact lenses while working at the computer? Yes No
(If yes, please wear them for your eye exam)
7. Do you view reference material while working at the computer? Yes No
(If yes, what percentage of time? _____)

In order for your VSP doctor to accurately assess your computer vision needs and possible appropriate eyewear, the following information must also be completed.

Distances/Direction

8. Viewing distance (eye to computer screen) is _____ inches.
9. Viewing distance (eye to keyboard) is _____ inches.
10. Viewing distance (eye to reference material) is _____ inches.
11. The center of the computer screen is (circle one):
above eye equal to eye below eye
level level level
If above or below, by how many inches?

12. Reference material is (circle one):
above eye equal to eye below eye
level level level
If above or below, by how many inches?

Please help us prescribe the most comfortable and functional prescription for you by providing the following information regarding how you use your eyes:

Occupational Needs
 Occupation _____
 Firm Employed by _____

Computer Work
 Hours used daily _____
 Used as: reference
 constant
 Is the screen at eye level
 above eye level
 below eye level
 What distance is the screen from your eyes? _____
 What is the color of the screen?

General Occupational Info
 If there are fluorescent lights at your work place, does their glare bother you?
 yes no
 If your occupation involves driving, how many hours? _____ hrs.
 Do you need/require safety eyewear?
 yes no
 Are you exposed to hazardous chemicals?
 yes no

If you are a student
 Favorite class/subject _____
 Your average grades _____
 Average amount of time to finish homework

 Any reading trouble? yes no
 Do you often skip words or lines or loose your place when reading? yes no
 Do you get headaches when reading?
 yes no
 Have you been told you work too close to your paperwork? yes no
 Other comments _____

Sports:
 Interest Level (in which you participate on a regular basis)
 Major Minor

<input type="radio"/>	<input type="radio"/>	Tennis/Racquet Sports
<input type="radio"/>	<input type="radio"/>	Swimming/Scuba
<input type="radio"/>	<input type="radio"/>	Jogging/Running
<input type="radio"/>	<input type="radio"/>	Basketball
<input type="radio"/>	<input type="radio"/>	Baseball
<input type="radio"/>	<input type="radio"/>	Football
<input type="radio"/>	<input type="radio"/>	Hunting/Shooting
<input type="radio"/>	<input type="radio"/>	Golf
<input type="radio"/>	<input type="radio"/>	Skiing
<input type="radio"/>	<input type="radio"/>	Fishing/Boating/Sailing
<input type="radio"/>	<input type="radio"/>	Cycling
<input type="radio"/>	<input type="radio"/>	Bowling
<input type="radio"/>	<input type="radio"/>	(other)
<input type="radio"/>	<input type="radio"/>	(other)

Hobbies/Activities
 Interest Level (in which you participate on a regular basis)
 Major Minor

<input type="radio"/>	<input type="radio"/>	Woodworking/Metalcraft
<input type="radio"/>	<input type="radio"/>	Driving
<input type="radio"/>	<input type="radio"/>	Gardening/Lawncare
<input type="radio"/>	<input type="radio"/>	Music
<input type="radio"/>	<input type="radio"/>	Reading
<input type="radio"/>	<input type="radio"/>	Traveling
<input type="radio"/>	<input type="radio"/>	Knitting/Needlework
<input type="radio"/>	<input type="radio"/>	Painting
<input type="radio"/>	<input type="radio"/>	Stamp/Coin Collecting
<input type="radio"/>	<input type="radio"/>	Photography
<input type="radio"/>	<input type="radio"/>	Aviation
<input type="radio"/>	<input type="radio"/>	Video: games/computer
<input type="radio"/>	<input type="radio"/>	(other)
<input type="radio"/>	<input type="radio"/>	(other)

Doctor's Notes _____

