



HOSPITALITY EYECARE
CENTER OF OPTOMETRY

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www.seetolive.com

DO I HAVE COMPUTER VISION SYNDROME?

Name _____

Contact Number _____

Date _____

Please identify the symptoms you experience. Comments on the severity and frequency of occurrence are helpful. All information noted below will be kept strictly confidential and is subject to HIPPA privacy laws. Please ask if you would like a personal copy of Hospitality Eyecare Center's Privacy Standards.

VISUAL

- _____ Blurred vision
- _____ Slow refocusing
- _____ Frequent loss of place
- _____ Doubling of vision
- _____ Squinting
- _____ Changes in color perception

OCULAR

- _____ Irritated or sore eyes
- _____ Itching and burning eyes
- _____ Excessive tearing
- _____ Dry eyes
- _____ Contact lens discomfort
- _____ Sore or hurting eyes

GENERAL

- _____ Eyestrain
- _____ Headache
- _____ Eye fatigue
- _____ Tired eyes

LIGHT

_____ Flickering sensations

_____ Glare

_____ Light Sensitivity

MUSCLE

_____ Neck or shoulder tension or pain

_____ Back pain

_____ Pain in arms, hands, wrists or shoulders

_____ Hip, leg, ankle or foot

OTHER

_____ Tension

_____ Excessive physical fatigue

_____ Irritability

_____ Increased nervousness

_____ More frequent errors

_____ General fatigue or drowsiness

Plases briefly answer the following questions:

How many hours per day do you work at the computer?

How many computer screens do you use at your work area?

How long can you use your computer(s) before symptoms occur?

How long ago did you notice symptoms first occurring?

Do your symptoms persist when you are not working? If YES, please describe.

Do you currently wear glasses and/or contact lenses for your computer work?

Is your prescription eyewear specialized for computer use? Or is it in general distance and near vision full-time wear?

Have you had any eye surgeries?

Have you had any known eye diseases?

How long ago was your last complete vision examination?

How long ago was your last complete medical examination?

Some medications have ocular side-effects. Do you currently take any medications? If so, please list.

Are there any specific concerns or questions you have regarding the ergonomics of your work area?

Are there any specific concerns or questions you have regarding your eyes in relation to your work environment and computer use?

Are there any other concerns or questions you would like your consultant to be aware of?

Please leave this questionnaire and Dr. Corbett will contact you soon to discuss your responses, offer suggestions and answer any questions you may have.