Ocular Wellness Questionnaire

Personal Information

Full Name: _____ Age: _____ Occupation: _____

Questions

In what type of environment do you typically spend MOST of your day? (Check all that apply.)

- ☐ Office
- ☐ Indoors
- ☐ Outdoors
- ☐ Driving
- ☐ Other (Please specify) _____

How much time do you spend each day?

	0-1 Hour	1-3 Hours	3-5 Hours	5+ Hours
☐ At a computer?	☐	☐	☐	☐
☐ On a smartphone or tablet?	☐	☐	☐	☐

Do your eyes feel tired after using a computer, smartphone, or tablet?

- ☐ Yes
- ☐ No

Do your eyes feel dry, irritated, burning, stinging or watery DURING or AFTER using a computer, smartphone, or tablet?

- ☐ Yes
- ☐ No

Do your eyes feel dry, irritated, burning, stinging or watery when NOT using a computer, smartphone, or tablet?

- ☐ Yes
- ☐ No

When driving at night, do the lights of other cars bother you?

- ☐ Yes
- ☐ No

Have you ever seen floaters in your vision?

- ☐ Yes
- ☐ No

If YES, how would you describe them? (Check all that apply.)

- ☐ Spots or specks
- ☐ Squiggly lines or threads
- ☐ Cobwebs or net-like pattern
- ☐ Other (please specify) _____

If YES, how often do you see the floaters?

- [ ] Rarely
- [ ] Occasionally
- [ ] Frequently
- [ ] Constantly

What types of leisure activities do you participate?

- [ ] Outdoor Activities (Please list):
- [ ] Indoor Activities (Please list):

Do you currently wear sunglasses to protect your eyes from UV when outdoors?

- [ ] Yes, I have Prescription sunglasses
- [ ] Yes, I have Non-Prescription sunglasses
- [ ] Yes, I have Transition lenses that darken when outdoors
- [ ] No

If you wear vision correction:

- [ ] Please list what you like about your current pair of glasses or contact lenses:
- [ ]
- [ ] Please list what you would change about your current pair of glasses or contact lenses:
- [ ]

What would you like to have on your next pair of glasses? (Check all that apply)

- [ ] Blue Light blocking protection
- [ ] Sunglasses
- [ ] Progressives (no-line bifocals)
- [ ] Transitions (lenses that darken when outdoors and clear when indoors)

What challenges are you having with your vision?

- [ ] Blurry vision when wearing my glasses
- [ ] Blurry vision when NOT wearing my glasses
- [ ] Dry eyes
- [ ] Itchy eyes
- [ ] Watery eyes
- [ ] Burning or stinging sensation
- [ ] Light sensitivity
- [ ] Headaches

Do you have any other concerns you would like addressed during your visit today?