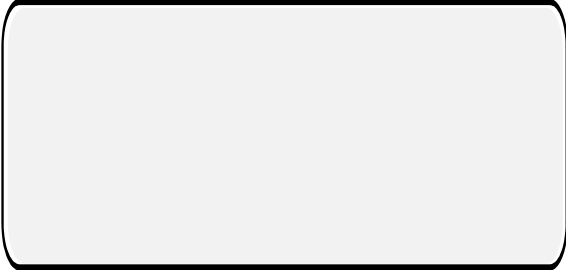


\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Today's Date

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient Name Date of Birth



### Digital Lifestyle Questionnaire

High efficiency light bulbs, flat screen TV's, computer monitors, laptops, tablets and smartphones continuously expose our eyes to high energy Blue light at unprecedented levels. These artificial light sources can disrupt your biological clock and cause digital eye strain - negatively impacting sleep, health and productivity.



The following questions will help us identify your level of exposure and develop a personalized action plan for overall improvement to your daily health and wellness.

**Please Note:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Please let us know if you experience any of the following symptoms: (check all that apply)

Symptom	Frequency		Time of Day		
<input type="checkbox"/> Headache	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Sore/Tired eyes	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Sleeplessness	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Difficulty focusing	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Daily fatigue	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening

### Digital Technology Exposure

Device / Technology	Avg. Exposure Time (# of hours ea)	Time of Day Used		
<input type="checkbox"/> Television		<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Computer		<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Tablet		<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Smart Phone		<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<b>Average total exposure time/day</b>				

### Work/home lighting environment

Light Technology	Avg. Exposure Time (# of hours ea)	Time of Day Used		
<input type="checkbox"/> LED lights		<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> Fluorescent lights		<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<b>Average total exposure time/day</b>				

After you have completed this form, either print and take with you to your appointment, or email it back to us. Thank you!