



Computer Vision 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
- 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 distances (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 equal to below
eye level eye level eye level

If above or below, by how many inches? _____

12. **Reference material is** (circle one)

above equal to below
eye level eye level eye level

If above or below, by how many inches? _____