

Number of hours per day spent at the computer: _____

Work is performed while:

Sitting

Other (please describe): _____

Describe the lighting in your work area:

fluorescent incandescent facing window

Other: _____

Are you experiencing any of the following symptoms while at your computer (check appropriate areas)?

Headaches Blurred near vision

Blurred distance vision

Slowness in focusing Double vision

Sore or tired eyes (strain)

Glare (light) sensitivity

Dry or watery eyes Burning, itching, or red eyes

Neck and shoulder pain Back pain

Do you wear glasses while working at the computer?

No Yes If yes, please bring them with you to the eye exam.

Do you wear contact lenses while working at the computer?

No Yes If yes, please wear them to the eye exam.

Do you view reference materials while working at the computer?

No Yes

If yes, what percentage of the time? _____

In inches, what is the viewing distance from your eye to the computer screen? _____

In inches, what is the viewing distance from your eye to the keyboard? _____

In inches, what is the viewing distance from your eye to reference material? _____

Please check where appropriate.

The center of the screen is above eye level.

The center of the screen is equal to eye level.

The center of the screen is below eye level.

If above or below, by how many inches?

Reference material is above eye level.

Reference material is equal to eye level.

Reference material is below eye level.

If above or below, by how many inches? _____