Lifestyle Questionnaire

How many hours do you spend each day on an electronic device? _____

What is your profession? _____

What are your hobbies? _____

Do you currently have sunglasses? ❑ Yes ❑ No

Do you currently have computer glasses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in LASIK? ❑ Yes ❑ No

Are you interested in Botox? ❑ Yes ❑ No

Would you like a complimentary anti-aging assessment? ❑ Yes ❑ No

Would you be interested in reducing fine lines and wrinkles around your eyes while reducing dry eye symptoms? ❑ Yes ❑ No

If you could change one thing about your glasses, what would it be?

Please rate the following on a scale from 1-5 with 1 being never and 5 being always:

Headaches (of any severity, usually getting worse later in the day)

1 2 3 4 5

Stiffness/pain in neck/shoulders (when working at a computer or reading)

1 2 3 4 5

Discomfort with computer use

1 2 3 4 5

Tired eyes (increasing throughout the day)

1 2 3 4 5

Dry Eye Sensation (worse on computer or reading)

1 2 3 4 5

Light Sensitivity (especially with stronger lights like headlights or fluorescents)

1 2 3 4 5

Dizziness (experience motion sickness or vertigo)

1 2 3 4 5

Please circle if your eyes experience the following:

Dry Eyes Redness Burning Excessive Tearing Foreign Body Sensation

Contact Lens Discomfort Stringy Mucous Fluctuating Vision

If you suffer from migraines, please see back page. →

AVULUX

Migraine & Light Sensitivity Eyewear

Patient Impact Assessment

Answer the following six questions about your experience with migraine by circling your best answer for each. Your Optometrist will use these results to help assess the impact of migraine on your life, and to provide recommendations to address your symptoms.

1. How many days per month do you suffer from migraine attacks?

   <1 1-4 5-8 9-12 13+

2. Do you experience light sensitivity or spend time in a dark room during your migraine attacks?

   YES NO

3. Are bright overhead lights, LEDs, computer or TV screens a known migraine trigger for you?

   YES NO

4. How would you rate the impact of migraine on your ability to function during an attack?

   I CAN FUNCTION NORMALLY | I CAN DO MOST ACTIVITIES | I CAN DO SOME ACTIVITIES | I CAN DO VERY FEW ACTIVITIES | I AM UNABLE TO FUNCTION

5. How often does your migraine impact your productivity or your ability to work?

   NEVER RARELY SOMETIMES OFTEN VERY OFTEN

6. How often does migraine impact personal plans; your ability to spend time with children, family or friends; or ability to complete daily tasks?

   NEVER RARELY SOMETIMES OFTEN VERY OFTEN