Computer Vision Symptom Assessment

Name: _____ Date: _____

Please circle whether or not (**Y** or **N**) you experience each of the following symptoms. For each **Y** answer, circle the appropriate number to identify the severity of the symptom.

Y N Eyestrain

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Tired Eyes

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Headache

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Irritated or sore eyes

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Dry eyes

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Lighting or glare discomfort

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Blurred Vision

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Neck or shoulder ache

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:

Y N Backache

		Mild					Moderate				Severe
If Yes, rate:	Severity	0	1	2	3	4	5	6	7	8	9	10

Comments:
