VSP VDT QUESTIONNAIRE

GENERAL VISUAL INFORMATION

1. Time spent at VDT? ______hrs per day.

2. Work is performed while: ☐ Sitting ☐ Other *(Please describe)*________________________

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2. Lighting in work area *(Please describe)*____

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Are you experiencing any of the following symptoms while at your VDT? Check where appropriate.

☐Headaches
☐Blurred Near Vision
☐Blurred Distance Vision
☐Burning, Itching, or Read Eyes
☐Slowness in Focusing *(Distabt to near and back)*
☐Double Vision
☐Sore or Tired Eyes (Strain)
☐Back Pain
☐Glare (Light) Sensitivity
☐Dry or Watery Eyes
☐Neck and Shoulder Pain

Do you wear glasses while working at the VDT? ☐Yes ☐No

Do you wear contact lenses while working at the VDT? ☐Yes ☐No

Do you view reference materials while working at the VDT? ☐Yes ☐No

If yes, what percentage of the time?____

In order for the doctor to accurately assess your occupational vision needs and possible appropriate eyewear, the following information must be completed.

DISTANCES/DIRECTION

Viewing distance (eye to VDT screen) is______________________inches.

Viewing distance (eye to VDT keyboard) is_____________________inches.

Viewing distance (eye to reference material) is__________________inches.

The center of the VDT screen is ☐above, ☐equal to, ☐below eye level.

If above or below, by how many inches?___________________

Reference material is ☐above, ☐equal to, ☐below eye level.

If above or below, by how many inches?___________________

NAME (Please Print):____

SIGNATURE:____

DATE:______________________