Migraine/Light Sensitivity Questionaire

FreSh VISION OPTOMETRISTS

Name:_____ **Date of Birth:**_____

Do you have or commonly experience any of the following:

- ☐ Eyestrain
- ☐ Light sensitivity
- ☐ Dry or irritated eyes
- ☐ Itchy eyes
- ☐ Migraine
- ☐ Headaches

Do you find that light can cause you eye pain, strain, or itchy eyes? Do you find yourself avoiding bright light situations? (ex. When exposed to bright or flashing lights or during extended screen time, or outdoors)

☐ Yes ☐ No

Do you ever find yourself sensitive to light or find light bothersome?

☐ Yes ☐ No

Have you been formally diagnosed with light sensitivity?

☐ Yes ☐ No

Is the light sensitivity related to a medical condition?

☐ Yes ☐ No If yes, which condition?_____

If migraine related light sensitivity, go to section 1.
If non-migraine related light sensitivity, go to section 2

Section 1 - Migraine Related Light Sensitivity (photophobia)

1. How many days per month do you experience migraine attacks? _____
2. Do your migraine attacks impact your activities of daily living? (need for a dark room, missed activities or work, unable to look at a computer screen or television for a prolonged period of time) ☐ Yes ☐ No
3. Would you consider light sensitivity to be your most bothersome migraine related symptom?

_____

4. Do you experience light sensitivity between migraine attacks? ☐ Yes ☐ No
5. What do you currently do to help mitigate the impact of light sensitivity?

_____

_____

_____

Section 2 - Non-Migraine Related Light Sensitivity

1. How long have you experienced light sensitivity?_____
2. Is the light sensitivity present only intermittently or is it constant?

_____

3. Is the light sensitivity severe enough that it impacts your activities of daily living? (not being able to go outside on sunny days, unable to look at a computer screen or television for a prolonged period of time) ☐ Yes ☐ No
4. Is the light sensitivity present only outdoors? Only indoors? Or both?

_____

5. If present indoors, are you impacted during screen time? (computer, mobile phone, or television) ☐ Yes ☐ No
6. What do you currently do to help mitigate the impact of light sensitivity?

_____

_____

_____

Thank you for trusting us with your eyecare