

Dry Eye Questionnaire

Form D-2 Upd: 04-05-10

Patient Name: _____ Date of Birth: _____

Today's Date: _____

SYMPTOMS

Over the past week, which of the following ocular symptoms have you experienced? Please check all that apply.

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Tearing | <input type="checkbox"/> Itching | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Redness | <input type="checkbox"/> Dryness | <input type="checkbox"/> Glare |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Ocular discomfort (aching) | <input type="checkbox"/> Light Sensitivity | |
| <input type="checkbox"/> Night driving problems | <input type="checkbox"/> Occasional blurred vision | <input type="checkbox"/> Decreased contact lens wearing time | |

Have you ever had eye surgery? (Examples: LASIK, PRK, Cataract)

- No Yes Please specify type of surgery and approximate date: _____

-
- | | | |
|--|------------------------------|-----------------------------|
| Do you notice matting on your eyelids when you wake in the morning | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are your eyelids swollen or red along the lash margins | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you experience burning in the morning | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a significant amount of crusting on your eyelids | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your vision fluctuate from clear to blurry | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Including after reading, watching TV, computer use, while driving or in the morning.

DEMOGRAPHIC INFORMATION

Please check any that apply to you. Are you:

- | | |
|--|--|
| <input type="checkbox"/> Female | <input type="checkbox"/> Pregnant or nursing |
| <input type="checkbox"/> Over age 40 | <input type="checkbox"/> A contact lens wearer |
| <input type="checkbox"/> A tobacco user | |
| <input type="checkbox"/> Using a computer more than one hour a day. | How many hours? _____ |
| <input type="checkbox"/> Reading for more than one hour a day. | How many hours? _____ |
| <input type="checkbox"/> Traveling in airplanes more than twice per month | |
| <input type="checkbox"/> Routinely using a ceiling fan in your bedroom while sleeping | |
| <input type="checkbox"/> Getting less than 7 hours of sleep per night in an average week | |

Approximately how many glasses of water do you drink per day?

- 3 or more
- Less than 3

Approximately how many servings of fish do you eat per week?

- 3 or more
- Less than 3

SYSTEMIC DISEASE

Which of the following conditions have you been diagnosed as having? Please check all that apply.

- | | | | |
|--|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Sleep disorders | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Facial Herpes Zoster (Shingles) | <input type="checkbox"/> Androgen Deficiency | | |

MEDICATIONS & SUPPLEMENTS

Do you take omega-3 supplements such as fish oil? Yes No

Name brand: _____

How many different medications do you currently take:

- 3 or more
- Less than 3

Do you currently take any of the following medications? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Beta blockers | <input type="checkbox"/> Anti-depressants |
| <input type="checkbox"/> Diuretics (LASIX) | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Hormone replacement therapy |
| <input type="checkbox"/> Active bladder therapy | <input type="checkbox"/> Accutane (even previously) | |

Do you use any of the following eye drops? Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Glaucoma drops | <input type="checkbox"/> Restasis - If yes, for how long: _____ |
| <input type="checkbox"/> Allergy drops | <input type="checkbox"/> Other |

Do you currently use or have you tried artificial tears Yes No

Brand name of the artificial tears: Please try to list as many as you recall using: _____

(Examples: Blink, Optive, Refresh, SootheXP, Systane, Visine, generic or store brand)

When used, how long does or did the relief last after you instill a drop of artificial tears

- Less than 15 minutes
- Less than 1 hour
- More than 1 hour

When used, typically how many artificial tear drops do or did you use per day?

- 4 or more
- 3 or less

Please add your comments about your dry eye condition: _____
