PATIENT DRY EYE **QUESTIONNAIRE**

Patient's Name: _____ Date:_____

Age:_____ Sex: _____M _____ F

I. Patient History

1. Have you ever been diagnosed with Dry Eye Disease? (Circle Answer) YES NO

If yes, when: _____

2. Have you had any of the following surgeries? (Circle All That Apply)

Cataract Refractive Glaucoma

3. Have you ever had any eye injuries? (Circle Answer) YES NO

If yes, when: _____

4. Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease? (Circle Answer)

YES NO If yes, which one and when?_____

4a. If YES, which previous dry eye treatments have you received? (Check All That Apply)

_____ Artificial Tears _____ Punctal Plugs _____ Lid Scrubs, Masks _____ Restasis

5. Do you currently use any of the following? (Check All That Apply)

_____ Contact Lenses _____ RX drops for Dry Eye (Restasis) _____ RX drops for Glaucoma

_____ RX Drops for Allergies _____ Nutritional Supplements

6. Have you been diagnosed with any of the following conditions? (Circle All That Apply)

Systematic Lupus	Arthritis	Heart Disease	Diabetes	Thyroid Disease
Depression	High Blood Pressure	Acne Rosacea	Acne	Sleeping Disorders
Sjogren's Syndrome	Multiple Sclerosis	Blepharitis	Cataract	Glaucoma

7. Are you taking any of the following medications (Circle All That Apply)

Antihistamines/decongestants	Antidepressants or anti-anxiety	Oral contraceptives
Hormone therapy or estrogen	Diuretics (water pills)	Blood Pressure Pills
Nasal corticosteroids	Other:_____	

II. Environmental Factors

8. Please circle one option for each category listed on the left:

Work in dusty or dry environments:	None	Low	Moderate	High
Computer & cell phone use:	None	Low	Moderate	High
Cigarette Smoker:	None	Low	Moderate	High
Seasonal Allergies:	None	Low	Moderate	High
Air Conditioned / Heated Areas:	None	Low	Moderate	High

III. Symptoms

9. Have you had any of the following symptoms (Check One Box (0-3) For Each Category Listed On Left)

Frequency	0 NEVER Never Occurs	1 SOMETIMES Occurs a few times per month	2 OFTEN Occurs a few times per day	3 CONSTANT Occurs all the time
Do your eyes feel dry, gritty, or scratchy?				
Do you have eye fatigue?				
Do you have blurred vision?				
Do your eyes burn or have pain?				
Do your eyes water?				
Do you have discharge from your eyes?				
Do your eyes appear red?				
Do your eyes have light sensitivity?				

10. What is the severity of your symptoms (Check One Box (0-3) For Each Category Listed On Left)

Severity	0 NO ISSUES No interference with daily activities	1 FAIRLY NOTICEABLE Mild interference with daily activities	2 ANNOYING Moderate interference with daily activity	3 PAINFUL Severe/Total interference with daily activities
Do your eyes feel dry, gritty, or scratchy?				
Do you have eye fatigue?				
Do you have blurred vision?				
Do your eyes burn or have pain?				
Do your eyes water?				
Do you have discharge from your eyes?				
Do your eyes appear red?				
Do your eyes have light sensitivity?				

11. How recently have you experienced the symptoms listed in the chart?

_____ Today

_____ Within the last week

_____ Within the last 3 months