Dry Eye Questionnaire

Date: ______/______/______

Name: ____ DOB: ______/______/______

Report the type of SYMPTOMS you experience and when they occur

Symptoms	At this Visit		Within the past 72 hrs		Within the past 3 months	
	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the type of FREQUENCY of the symptoms
0 - Never 1 - Sometimes 2 - Often 3 - Constant

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the SEVERITY of the symptoms
0 - No Problems 1 - Tolerable (not perfect, but does not cause discomfort) 2 - Uncomfortable (irritating, does not bother my day) 3 - Bothersome (irritating and bothers my day) 4 - Intolerable

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

/28

1. Please mark with an “X” any previous medications or eyedrops you have tried in the past:
   ___Systane: _____ drops ____gel ____ointment
   ___Refresh: _____ drops ____gel ____ointment
   ___Blink: _____ drops ____gel
   ___Theratears: _____ drops ____gel
   ___Other drops (Please list) ____
   ___Redness Reliever Eyedrops: _____ Lumify ____Visine ____Clear Eyes
   ___ Allergy Eyedrops: _____ Naphcon-A ____Pataday ____Alaway____Lastacaft
   ___ Dry Eye Medications: _____ Restasis ____Xiidra ____Cequa
   ___Tryvaya Nasal Spray
   ___Steriod eye Drops (Please list) ______________________________________
   ___Omega 3 Vitamins (Please list) ______________________________________
   ___Others (Please list) ____

2. What are you currently taking for your dry eyes? List below or <u>CIRCLE</u> from list above.

3. Do you use warm compresses on your eyes?
4. Do you use eyelid scrubs/washes?
5. Do you experience seasonal allergies that affect your eyes?
6. On average, how many hours do you sleep each night?
7. On average, how many cups of water do you drink each day?
8. On average, how many hours do you spend on a screen (computer/tablet/phone/etc)?
9. Do you have dry mouth symptoms?
10. Do you have rosacea (skin condition with flushing of cheeks)?
11. Have you had any of these procedures/treatments in the past?
    ___Optilight (Light based Treatment) or Intense Pulsed Light (IPL) Treatment
    ___Thermal Pulsation (Lipiflow/Mibo/iLux/Tearcare)
    ___ Punctal Plugs
    ___ Blephadex / ZEST
    ___ Biologics (Amniotic Membrane or Regenereyes eyes drop)
    ___ Autologous Serum
    ___ Other
    ___ None