Dry Eye Questionnaire

Subjective demographics and history

Date of birth __ __ / __ __ / __ __ Age _____ Gender □ Male □ Female Ethnicity _____

1. Special considerations. Please check all that apply:
   □ Pregnant or nursing
   □ Air travel more than twice per month
   □ Routinely use ceiling fan in bedroom
   □ Ocular surgery (LASIK, PRK, cataract surgery)
   □ Computer use of more than one hour per day
   □ Tobacco user
   □ Alcohol user
   □ Allergies

2. Systemic medications. Please check all that apply:
   □ Birth control pills
   □ Beta blockers
   □ Diuretics "water pills" (LASIX)
   □ Antihistamines
   □ Anti-depressants
   □ Hormone replacement therapy
   □ Nasal corticosteroids (Flonase, Nasacort)
   □ Fosamax

3. Ocular medications. Please check all that apply:
   □ Glaucoma drops
   □ Allergy drops
   □ Restasis

4. Do you use artificial tears? □ Yes □ No
   a. If yes, how many times a day do you need them?
   □ Once □ Twice □ Three □ Four □ More than four

   If yes, what type of artificial tears do you use?

□ Refresh tears	□ Refresh Liquigel	□ Refresh Endura
□ Refresh Dry Eye Therapy	□ Systane	□ Systane Free
□ Visine	□ Thera Tears	□ Blink
□ Soothe	□ Optive	□ Other _____

5. Have you been diagnosed with dry eye? □ Yes □ No

6. Do you think you have dry eye? □ Yes □ No

7. Do you have dry nasal passages or dry mouth?
   □ Yes, dry nasal passages □ Yes, dry mouth □ No

8. How often do you experience dryness? Please choose one:
□ None □ Sometimes □ Frequently □ Always

9. Previous dry eye treatments. Please check all that apply:

	Was this successful? ***Yes***	***No*** ***Describe***
□ AT	□	□ _____
□ Punctal occlusion	□	□ _____
□ Nutriceutials	□	□ _____
□ Lid scrubs/massages	□	□ _____
□ Restasis	□	□ _____
□ Other _____	□	□ _____

10. Do you wear contact lenses? □ Yes □ No
a. If yes, please provide lens and lens care information:
Do you re-wet your contact lenses? □ Yes □ No
b. If yes, with which drop? _____
How many times per day?
□ Once □ Twice □ Three □ Four □ More than four
c. How many comfortable wearing hours do you have per day? _____
d. Do you have dry eye symptoms when not wearing contact lenses? □ Yes □ No

11. With which of the following conditions have you been diagnosed?
Please check all that apply:

□ Thyroid disease	□ Arthritis	□ Diabetes
□ Lupus	□ Acne Rosacea	□ Sleep disorders
□ Depression	□ Acne	□ Sjogren's syndrome
□ Psoriasis	□ Seborrhea	□ Multiple Sclerosis
□ High blood pressure	□ Facial Herpes Zoster (Shingles)	

Subjective symptomatology

.	Never (Score 0)	Rarely (Score 1)	Sometimes (Score 2)	Often (Score 3)	All the time (Score 4)	Which symptom is the worst? (**Mark with *W***)	Which symptom is the most bothersome? (***Mark with B***)
Do your eyes ever feel dry?							
Do you ever feel a gritty or sandy sensation in your eye?							
Do your eyes ever have a burning sensation?							
Are your eyes ever red?							
Do you notice much crusting on your lashes?							
Do your eyes ever get stuck shut in the morning?							
Do you have teary eyes?							

Total _____ (A score greater than 7 indicates dry eye)