DRY EYE CLINIC QUESTIONNAIRE

INITIAL EVALUATION

PATIENT NAME_____ CHART NUMBER_____ DATE _____

Please answer the following questions by circling the correct answer where appropriate.

1. Sex Male Female
2. Age 20-35 36-45 46-55 56-65 66-90+
3. Do you feel like you have something in your eye, a sandy or gritty sensation? **Never/Sometimes/Often/Constantly**
   Does it feel better when you rub your eyes? **Yes/No**
4. Does your vision seem to fluctuate when you read? **Never/Sometimes/Often/Constantly**
5. Do you suffer from intermittent blurred vision? **Never/Sometimes/Often/Constantly**
   Does your blurred vision clear immediately after the blink and then blur again? **Yes/No**
6. Do your eyes feel sticky or stuck shut in the morning? **Never/Sometimes/Often/Constantly**
   Does washing your eyes seem to help them feel better? **Yes/No**
7. Do you suffer from frequent styes? **Yes/No**
8. Do your eyes tear or water excessively? **Never/Sometimes/Often/Constantly**
9. Did you ever take Accutane® for an acne problem? **Yes/No**

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10. Have you been treated for dry eyes in the past? If so, what therapy was used and what were the results? _____
    _____
11. Do you currently use any type of artificial tear? **Yes/No**
    Name_____ How long have they been used? _____ How often during the day?_____
12. Do your eyes burn? **Never/Sometimes/Often/Constantly**
    When does it start? _____ How long does it last? _____
13. Do your eyes get tired? **Never/Sometimes/Often/Constantly**
14. Do your eyes feel sore when blinking or moving your eyes? **Never/Sometimes/Often/Constantly**
15. Do you have sensitivity to bright lights or sunshine? **Never/Sometimes/Often/Constantly**
16. Are you sensitive to cigarette smoke? **Never/Sometimes/Often/Constantly**
17. Do you have increased dryness in AC or central heating? **Never/Sometimes/Often/Constantly**

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18. Do your eyes itch? **Never/Sometimes/Often/Constantly**
19. Are your lids usually red or puffy? **Never/Sometimes/Often/Constantly**
20. Do you have frequent eye infections? **Yes/No**
21. Do you have discharge from your eyes? **Never/Sometimes/Often/Constantly**
    Please describe the discharge._____
22. Have you ever had eyelid surgery? **Yes/No**
23. Have you ever had an injury to your eyes or eyelids? **Yes/No**

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24. Do you wear contact lenses? **Yes/No**
    Circle the type you wear **RGP, Soft daily, soft extended wear**
    How long do you wear them?_____hrs/day How many years _____ years
    Are your lenses comfortable? **Yes/No**
25. Are your eyes sensitive to the contact lens solution? **Yes/No**
26. Have you worn lenses before but quit wearing them due to discomfort? **Yes/No**

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27. Are you taking any prescription medications or over the counter medications including supplements and herbal remedies?
    Antihistamines Cold Medication Diuretics (water pills)
    Hormone replacement Thyroid Medications Hypertension medications
    Tranquilizers Anti-anxiety medications
    Please List any other medications _____
    _____
28. Do you have any of the following: (Please Circle)
    Allergies —To What?? _____
    Asthma Thyroid Disorder Headaches
    Joint pain or arthritis Muscle Soreness Dry mouth or throat
    Chronic cough Nasal or sinus congestion Runny Nose Sneezing
29. Have you ever had any kind of ocular surgery including refractive surgery? **Yes/No**
    If yes, please specify surgery, which eye, when performed and surgeons name and city of practice
    _____
    _____

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