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| Dry Eye QUESTIONNAIRE |
| Name: |  | 🞎 M 🞎 F | Date:  |  |
| Do you experience? (check all that apply):  | 🞎 Stinging 🞎 Burning 🞎 Tearing 🞎 Grittiness 🞎 Redness 🞎 Puffy Eyelids 🞎 Decreased Contact Lens Wearing Time 🞎 Light sensitivity  |
| Special Considerations (check all that apply): | 🞎 Pregnant or Nursing 🞎 Tobacco user 🞎 Air Travel more than 2x month 🞎 Ceiling fan in bedroom  🞎 Ocular Surgery (Lasik, PRK, Cataract) 🞎 Computer use 🞎 Allergies  |  |
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| **Systemic Medications (check all that apply):**🞎 Birth control 🞎 Beta blockers 🞎 Diuretics 🞎 Antihistamines 🞎 Anti-depressants 🞎 Hormonal Replacement Therapy 🞎 Nasal Corticosteroids **Ocular Medications (check all that apply):**🞎 Allergy 🞎 Restasis🞎 Glaucoma drops 🞎 Artificial tears 🞎 Anti-inflammatory |
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| 1. | **Do you use artificial tears?** 🞎 Yes 🞎 No  | **Previous Dry Eye treatments:**( Artificial Tears, Punctal Occlusion, Nutriceuticals, lid scrubs, Restasis, other): \_\_\_\_\_\_\_\_\_\_\_\_**Successful (describe)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.  | **If YES, how many times a day?** 🞎 1/day 🞎 2/day 🞎 3/day 🞎 >4/day  |
| 3. | **If YES, what types of tears do you use?** 🞎 Refresh tears 🞎 Refresh Liquigel 🞎 Systane 🞎 Optive 🞎 Thera tears 🞎 Soothe XP 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_  |
| 4. | **Have you been diagnosed with dry eye disease?** 🞎 Yes 🞎 No  |
| 5. | **Do you think you have Dry Eyes?** 🞎 Yes 🞎 No  |
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| 6. | **Contact Lens Wear?** 🞎 Yes 🞎 No  | **Which of the following conditions have you been diagnosed with?** 🞎 Thyroid disease 🞎 Arthritis 🞎 MS 🞎 Diabetes 🞎 Acne Rosacea 🞎 Lupus 🞎 Psoriasis 🞎 Sjogren’s Syndrome🞎 Facial Herpes Zoster (shingles)  |
| 6a. | **If yes, brand and solution:** |
| 7. | **Are you using artificial tears with contacts?** 🞎 Yes 🞎 No  |
| 8. | **Number of comfortable wearing hours?** 🞎 Yes 🞎 No  |
| 9. | **Do you have dry eye symptoms only when wearing your contacts?** 🞎 Yes 🞎 No  |