|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | |  |
|  | | | | | | | | |
| **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 | | | | | | | | |
|  | | | | | | | | |
| 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 | | | | |
|  | | | | | | | | |
| 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 | | | | |