

# DRY EYE QUESTIONNAIRE

Patient Name or ID: \_\_\_\_\_ Date: \_\_\_\_\_

Technician: \_\_\_\_\_

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

Y  N When? \_\_\_\_\_

Do you have any of the following symptoms?

- |   |  |
|---|--|
| <input type="checkbox"/> Blurry vision                | <input type="checkbox"/> Tired eyes, eye fatigue                     |
| <input type="checkbox"/> Redness                      | <input type="checkbox"/> Stringy mucus in or around the eyes         |
| <input type="checkbox"/> Burning                      | <input type="checkbox"/> Foreign body sensation                      |
| <input type="checkbox"/> Itching                      | <input type="checkbox"/> Contact lens discomfort                     |
| <input type="checkbox"/> Light sensitivity            | <input type="checkbox"/> Scratchy feeling of sand or grit in the eye |
| <input type="checkbox"/> Excess tearing/watering eyes |  |

Have you had any of the following surgeries?

Cataract:  Y  N    Glaucoma:  Y  N    Refractive Surgery:  Y  N

Do you use?

- Contact lenses
- OTC eye drops such as artificial tears
- Rx eye drops for Dry Eye Syndrome (e.g., Restasis)
- Rx eye drops for Glaucoma (e.g., Xalatan, Timolol)
- Rx eye drops for Allergy (e.g., anti-inflammatory, antihistamine)
- Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

- Windy conditions
- Places with low humidity (e.g., airplanes/hospital)
- Areas that are air conditioned/heated

Are you taking any of the following medications?

- Antihistamines/decongestants
- Antidepressant or anti-anxiety
- Oral corticosteroids
- Hormone replacement therapy or estrogen
- Antihypertensives (e.g. diuretic, beta-blocker)
- Accutane or other oral treatment for acne

Have you ever had punctal occlusion?  Y  N

*If the information provided in this form, in conjunction with other clinical data, raises the suspicion of Dry Eye Disease, then obtaining a Tear Osmolarity Test may be indicated.*

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has Dry Eye Disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician: \_\_\_\_\_ Date: \_\_\_\_\_