Dry Eye Questionnaire

Demographic Information

Please circle all that apply to you:

Female Pregnant or nursing Over age 40 A tobacco user

Use a computer more than 1 hour a day _____ hrs

Reading for more than 1 hour per day

A contact lens wearer

Have you ever had eye surgery? (Lasik, PRK, Cataract surgery, other)
Yes, please specify_____ No

Travel in airplanes >2 x a month Routinely using a ceiling fan in your bedroom

Drink more than 3 caffeinated beverages (cola, coffee or tea) per day

Getting less than 7 hours of sleep per night in an average week

Approximately how many glasses of water do you drink PER DAY?

3 or more Less than 3

Approximately how many servings of fish do you eat per week?

3 or more Less than 3

Do you take omega-3 supplements such as fish oil? Yes No

Name Brand_____ How Much? _____

How many medications (different Pills) do you currently take?

3 or more Less than 3

Do you currently take any of the following medications?

3 or More Less than 3

Do you currently take any of the following medications?

Birth control pills Antihistamines

Beta Blockers Anti Depressants

Diuretics(lasix) Hormone replacement therapy

Active Bladder therapy Accutane(even previously)

Do you use any of the following eye drops?

Glaucoma Drops Allergy drops Other_____

Systemic Disease

Which of the following have you been diagnosed with? (check all that apply)

□ Thyroid disease □ Arthritis □ Diabetes □ Lupus □ Acne Rosacea

□ Sleep disorders □ Sarcoid □ Facial Herpes Zoster (Shingles)

□ MS □ _____

Other questions

Do you notice mattering on your eyelids when you wake in the morning Yes ☐ No ☐

Are your eyelids swollen or red along the lash margins Yes ☐ No ☐

Do you experience burning in the morning Yes ☐ No ☐

Do you have a significant amount of crusting on your eyelids Yes ☐ No ☐

Does your vision fluctuate from clear to blurry especially in the morning (including after reading, watching TV, computer or driving) Yes ☐ No ☐

Do you use or have you tried Artificial Tears? Yes ☐ No ☐

Brand name of Artificial Tears: _____

When used, how long does/did the relief last after you instill a drop of artificial tears?

☐ Less than 15 minutes ☐ Less than 1 hour ☐ More than 1 hour

When used, typically how many artificial tear drops do or did you use per day?

☐ 4 or more ☐ 3 or less

Have you experienced any of the following during the last week:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
Eyes that are sensitive to light?	4	3	2	1	0
Eyes that feel gritty?	4	3	2	1	0
Painful or sore eyes?	4	3	2	1	0
Blurred Vision?	4	3	2	1	0
Poor Vision?	4	3	2	1	0

Have problems with your eyes limited you in performing any of the following during the last week:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
Reading?	4	3	2	1	0
Driving at night?	4	3	2	1	0
Working with a computer or Bank Machine (ATM)	4	3	2	1	0
Watching TV	4	3	2	1	0

Have your eyes felt uncomfortable in any of the following situations during the last week:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
Windy Conditions?	4	3	2	1	0
Places or areas with Low humidity (very dry)?	4	3	2	1	0
Areas that are air conditioned?	4	3	2	1	0