Dry Eye Questionnaire

Patient Name or ID: _____ **Date**: _____
Technician: _____
Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Yes ☐ No If so, When?_____

Do you have any of the following symptoms?

- ☐ Blurry Vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light Sensitivity
- ☐ Excess Tearing/Watering Eyes
- ☐ Tired Eyes, Eye Fatigue
- ☐ Stringy mucus in or around the eyes
- ☐ Foreign body Sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand or grit in the eye

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 punctual occlusion? ☐ Y ☐ N

If the information provided in this form, in conjunction with other clinical date, raises the suspicion of Dry Eye Disease, then obtaining a Dry Evaluation and Consult 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 complete Dry Evaluation & consult is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician:_____ **Date:**_____