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## Dry Eye Questionnaire

1. How often do you experience any of the following symptoms?				
	Never	Occasionally	Frequently	Constantly
Redness				
Sandy or gritty sensation				
Itching				
Excess watering				
Burning				
Excess mucous discharge				
Fluctuating/blurred vision (corrected with blinking)				
2. Are your eyes sensitive to these conditions?				
	Never	Occasionally	Frequently	Constantly
Smoke				
Air pollutants				
Wind				
Computer glare				
Air conditioning or heaters				
Contact lenses				
Light				
3. How often do you use the following medications?				
	Never	Rarely	As Needed	Daily
Anti-depressants				
Antihistamines				
Decongestants				
Diuretics				
Beta Blockers				
Oral contraceptives				
Hormone replacement therapy				
Ulcer medications				
Incontinence medications				
Artificial tears (brand: _____)				
Redness reducing eye drops				
4. Have you ever been diagnosed with any of the following conditions?				
	No	Yes		
Thyroid problems				
Sleep disorders				
Arthritis				
Diabetes				
Sarcoidosis				
Herpes Zoster (Shingles)				
Systemic Lupus				
Rosacea				
5. Are you over age 50?				
6. Are you post-menopausal?				
7. Do you blink excessively?				
8. Do you experience contact lens discomfort?				
9. Have you ever had refractive surgery? (RK, PRK, LASIK, LASEK)				

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Chart: \_\_\_\_\_