Dry Eye Questionnaire

Subjective demographics and history
Date of birth __ ___ / ___ ___ / ___ ___  Age ______  Gender □ Male □ Female  Ethnicity __________

1. Special considerations. Please check all that apply:
   □ Pregnant or nursing
   □ Air travel more than twice per month
   □ Routinely use ceiling fan in bedroom
   □ Ocular surgery (LASIK, PRK, cataract surgery)
   □ Computer use of more than one hour per day
   □ Tobacco user
   □ Alcohol user
   □ Allergies

2. Systemic medications. Please check all that apply:
   □ Birth control pills
   □ Beta blockers
   □ Diuretics “water pills” (LASIX)
   □ Antihistamines
   □ Anti-depressants
   □ Hormone replacement therapy
   □ Nasal corticosteroids (Flonase, Nasacort)
   □ Fosamax

3. Ocular medications. Please check all that apply:
   □ Glaucoma drops
   □ Allergy drops
   □ Restasis

4. Do you use artificial tears? □ Yes  □ No
   a. If yes, how many times a day do you need them?
      □ Once  □ Twice  □ Three  □ Four  □ More than four

      If yes, what type of artificial tears do you use?
      □ Refresh tears    □ Refresh Liquigel   □ Refresh Endura
      □ Refresh Dry Eye Therapy  □ Systane    □ Systane Free
      □ Visine  □ Thera Tears  □ Blink
      □ Soothe  □ Optive  □ Other ___________________

5. Have you been diagnosed with dry eye? □ Yes  □ No

6. Do you think you have dry eye? □ Yes  □ No

7. Do you have dry nasal passages or dry mouth?
   □ Yes, dry nasal passages    □ Yes, dry mouth  □ No
8. How often do you experience dryness? Please choose one:
   □ None    □ Sometimes    □ Frequently    □ Always

9. Previous dry eye treatments. Please check all that apply:
   
<table>
<thead>
<tr>
<th>Was this successful?</th>
<th>Yes</th>
<th>No</th>
<th>Describe</th>
</tr>
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<tbody>
<tr>
<td>□ AT</td>
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<tr>
<td>□ Punctal occlusion</td>
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<td>□ Nutriceutials</td>
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<td>□ Lid scrubs/massages</td>
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<td>□ Restasis</td>
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<td>□ Other _____________</td>
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10. Do you wear contact lenses?    □ Yes    □ No
    a. If yes, please provide lens and lens care information:
       Do you re-wet your contact lenses? □ Yes    □ No
    b. If yes, with which drop? ______________________________
       How many times per day?
       □ Once    □ Twice    □ Three    □ Four    □ More than four
    c. How many comfortable wearing hours do you have per day? ______
    d. Do you have dry eye symptoms when not wearing contact lenses? □ Yes    □ No

11. With which of the following conditions have you been diagnosed?
    Please check all that apply:
    □ Thyroid disease    □ Arthritis    □ Diabetes
    □ Lupus    □ Acne Rosacea    □ Sleep disorders
    □ Depression    □ Acne    □ Sjogren’s syndrome
    □ Psoriasis    □ Seborrhea    □ Multiple Sclerosis
    □ High blood pressure    □ Facial Herpes Zoster (Shingles)
Subjective symptomatology

<table>
<thead>
<tr>
<th>.</th>
<th>Never (Score 0)</th>
<th>Rarely (Score 1)</th>
<th>Sometimes (Score 2)</th>
<th>Often (Score 3)</th>
<th>All the time (Score 4)</th>
<th>Which symptom is the worst? (Mark with W)</th>
<th>Which symptom is the most bothersome? (Mark with B)</th>
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<tbody>
<tr>
<td>Do your eyes ever feel dry?</td>
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<td>Do you ever feel a gritty or sandy sensation in your eye?</td>
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<td>Do your eyes ever have a burning sensation?</td>
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<td>Are your eyes ever red?</td>
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<td>Do you notice much crusting on your lashes?</td>
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<td>Do your eyes ever get stuck shut in the morning?</td>
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<tr>
<td>Do you have teary eyes?</td>
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**Total _________**  (A score greater than 7 indicates dry eye)