Ocular Surface Health **Questionnaire**

NAME ______________________________

Check all symptoms experienced since last visit.

- ☐ Dry Eyes
- ☐ Blurry Vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excessive tearing/watery eyes
- ☐ Tired eyes/eye fatigue
- ☐ Stringy mucous in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy, feeling of sand or grit in eye
- ☐ Fluctuating Vision

Have you ever treated yourself for dry eyes? ☐Yes ☐No

Have you used any eye drops in the last 2 hours? ☐Yes ☐No

FOR OFFICE USE ONLY Doctor's Order Initials ______________ Date ______________

Osmolarity Measurements

Right Eye (OD) ______________ *(mOsms/L)* Left Eye (OS) ______________ *(mOsms/L)*

Inter-eye difference is > 8mOsm/L	☐ Yes	☐ No	
Osmolarity	☐ Normal	☐ Abnormal	
Patient Dry Eye Severity	☐ Mild	☐ Moderate	☐ Severe
Schedule for Dry Eye Workup	☐ Yes	☐ No	

300 320 340

(mOsms/L)

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