DRY EYE **QUESTIONNAIRE**

Patient Name or ID: _____ Date: _____

Technician: _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Y ☐ N 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 punctal occlusion? ☐ Y ☐ N

If the information provided in this form, in conjunction with other clinical data, raises the suspicion of Dry Eye Disease, then obtaining a Tear Osmolarity Test 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 tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician: _____ Date: _____

*Tradenames are the property of their respective owners.