Patient Name or ID: ___________________________ Date: ___________________________

Technician: ___________________________

Do you have any of the following symptoms?
- [ ] Dry eyes
- [ ] Blurry vision
- [ ] Redness
- [ ] Burning
- [ ] Itching
- [ ] Light sensitivity
- [ ] Fluctuating Vision
- [ ] 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 used any eye drops in the last 2 hours?
- [ ] YES
- [ ] NO

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?
- [ ] YES
- [ ] NO
- When? ________________

If YES, is your appointment today to monitor dry eye treatment?
- [ ] YES
- [ ] NO

Are you here to be evaluated for:
- [ ] Cataract Surgery
- [ ] LASIK
- [ ] Other Surgery

Do you use?
- [ ] Contact lenses
- [ ] Over the counter eye drops such as artificial tears
- [ ] Eye drops for dry eye disease (e.g., Restasis*, Xiidra*)
- [ ] Eye drops for glaucoma (e.g., latanoprost, Travatan*, Lumigan*)
- [ ] Eye drops for allergy (e.g., Pred Forte*, Pataday*)
- [ ] Nutritional supplements (e.g., omega-3)

Have you ever been diagnosed with any of the following:
- [ ] Sjogrens Syndrome
- [ ] Rosacea
- [ ] Multiple Sclerosis
- [ ] Rheumatoid Arthritis
- [ ] Thyroid Disease

Have you ever had punctal plugs?
- [ ] YES
- [ ] NO

FOR OFFICE USE ONLY - OSMOLARITY MEASUREMENTS

Doctor’s Order Initials ____________ Date ____________

RIGHT EYE (mOsm/L) ____________ LEFT EYE (mOsm/L) ____________

Osmolarity
- [ ] Normal
- [ ] Abnormal

Schedule for Dry Eye Workup
- [ ] Yes
- [ ] No