Patient Dry Eye Questionnaire

Name: Date:

❖ *Circle the number that best describes your condition and enter the number in the score column.*

How often do you have these eye problems?	**Never**	**Sometimes**	**Frequently**	**Always**	**Score**
Redness	0	3	4	5	
Sandy or Gritty Sensation	0	4	5	6	
Itching	0	3	4	5	
Excess Watering	0	3	4	5	
Burning	0	4	5	6	
Excess Mucous	0	3	4	5	
Blurred Vision (Corrected by blinking)	0	4	5	6	
Are your eyes sensitive to these conditions?	**Never**	**Sometimes**	**Frequently**	**Always**	**Score**
Smoke	0	2	3	4	
Light	0	2	3	4	
Air Pollution	0	2	3	4	
Wind	0	2	3	4	
Computer Screens	0	2	3	4	
Heaters	0	2	3	4	
Air Conditioning	0	2	3	4	
Contact Lenses	0	2	3	4	
How often do you use these medications?	**Never**	**Sometimes**	**Frequently**	**Always**	**Score**
Anti-Depressants	0	1	2	3	
Redness Reducing Eye Drops	0	1	2	3	
Decongestants	0	1	2	3	
Antihistamines	0	1	2	3	
Blood Pressure Medication	0	3	4	3	
Artificial Tears (lubricating drops)	0	1	2	3	
Hormones	0	1	2	3	
Oral Contraceptives	0	1	2	3	
Diuretics	0	1	2	3	
Ulcer Medications	0	1	2	3	
Tranquilizers	0	1	2	3	
Beta Blockers	0	1	2	3	
Have you been diagnosed with any of these conditions?		**Yes**	**No**		**Score**
Thyroid Abnormalities		2	0		
Rheumatoid Arthritis		2	0		
Asthma		2	0		
Diabetes		2	0		
Glaucoma		2	0		
Lupus		2	0		
		Yes	**No**		**Score**
Are you over 50 years of age?		5	0		
Are you post menopausal?		5	0		
Do you get eye strain?		4	0		
Do you blink your eyes excessively?		4	0		
Total the numbers in the score column. If your score was 30 or higher, or you suspect you may have Dry Eye Syndrome, take this form to your scheduled eye examination. Review your symptoms with your doctor so that she can provide treatment options.					Total Score