Dry Eye Questionnaire

Patient Name or ID _____ **Date:** _____

Technician: _____

Have you 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 of 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.,* diruetic, 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:** _____