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Dry Eye Disease Questionnaire

The first step in determining the nature of your dry eye disease condition is to gain a complete understanding of all the factors that may contribute to your condition. Please take your time and answer the following questions as carefully as possible.

Please circle the number in the box that best represents each answer.

Have you experienced any of the following during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light?...	4	3	2	1	0
2. Eyes that feel gritty?....................	4	3	2	1	0
3. Painful or sore eyes?....................	4	3	2	1	0
4. Blurred vision?............................	4	3	2	1	0
5. Poor vision?.................................	4	3	2	1	0

Have problems with your eyes limited you in performing any of the following during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
6. Reading?.....................................	4	3	2	1	0	N/A
7. Driving at night?..........................	4	3	2	1	0	N/A
8. Working with a computer or bank machine?............................	4	3	2	1	0	N/A
9. Watching TV?.............................	4	3	2	1	0	N/A

Have your eyes felt uncomfortable in any of the following situations during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
10. Windy conditions?....................	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?.................	4	3	2	1	0	N/A
12. Areas that are air conditioned?..	4	3	2	1	0	N/A

To the best of your knowledge how long have you had dry eye disease?____________________

Do your eyes feel worse any particular time of the day (upon waking, morning, afternoon, night)?
____

Do your eyes feel worse when you are doing anything in particular (driving, watching TV, reading, using a computer, etc.)?____
____
____
____

Do you ever wake with your lids or eye crusted or swollen?__________________________
Do you have any allergies (itching) or sinus issues? Please list:_______________________
____

Please check mark next to all treatments that you have used in the past for your dry eye condition. If you are not sure about an item please put a question mark next to the item.

( ) Artificial Tears ( ) Hot Compresses ( ) Restasis ( ) Steroid Drops

( ) Punctal Plugs ( ) Night time Ointment ( ) Doxycycline Tablets

( ) Meibomian Gland Expression ( ) Omega 3 Nutrition Supplement

Please list any treatments or procedures that you have used in the past that you feel might have worked, even for a short time. ____
____
____
____
____

If you have used lubricating drops in the past, can you list any that you liked or didn't like and why? Examples of some are: Sustain Ultra, Sustain Balance, Retaine, Blink, Thera-Tears, FreshKote etc..

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Please list any treatments or procedures that you have used in the past that you feel did not work at all.____
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