



BELLEVUE

EYE ASSOCIATES

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Dry Eye Questionnaire

Patient Name: _____

Date: _____

Demographic information

1. Please check any that apply to you. **Are you:**

Female? Using a computer more than 1 hour a day? ___ hrs

Pregnant or Nursing? Reading for more than 1 hour per day?

Over age 40? A contact lens wearer?

A Tobacco user?

Traveling in airplanes more than twice per month?

Routinely using a ceiling fan in your bedroom?

Drinking more than 3 caffeinated (coffee, tea or cola's) drinks per day?

Getting less than 7 hours of sleep per night in an average week?

Approximately how many glasses of water do you drink **per day**?

3 or more

Less than 3

Approximately how many servings of fish do you eat **per week**?

3 or more

Less than 3

2. How many medications (different pills) do you currently take?

3 or more

Less than 3

3. Do you currently take any of the following medications? (Please check all that apply)

Birth control pills Antihistamines

Beta blockers Anti-depressants

Diuretics (LASIX) Hormone Replacement therapy

4. Do you use any of the following eye drops? (Please check all that apply)

Glaucoma drops

Allergy drops

Other _____

Symptoms

1. Over the past week, which of the following ocular symptoms have you experienced?

Stinging **Tearing** **Itching** **Grittiness** **Burning**
Decreased contact lens wearing time **Redness** **Glare**
Occasional Blurred vision **Dryness** **Night driving problems**
Ocular Discomfort (aching) **Light Sensitivity** **Dry mouth**

2. Have you ever had eye surgery (LASIK, PRK, Cataract Surgery, other)?

Yes (**Please specify**) _____ No

Systemic Disease

1. Which of following conditions have you been diagnosed with? (check all that apply)

Thyroid disease **Arthritis** **Diabetes** **Lupus** **AcneRosacea**
Sleep disorders **Sarcoid** **Facial Herpes Zoster (Shingles)** **MS**

Other questions

Do you notice mattering on your eyelids when you wake in the morning Yes No

Are your eyelids swollen or red along the lash margins Yes No

Do you have a significant amount of crusting on your eyelids Yes No

Does your vision fluctuate from clear to blurry throughout the day
(including after reading, watching TV, computer or driving) Yes No

Do you use artificial Tears? Yes No Brand name _____

If yes, how long does the relief last after you instill a drop of artificial tears?

Less than 15 minutes

Less than 1 hour

More than 1 hour

If yes, typically how many artificial tear drops do you use per day?

4 or more

3 or less