

DRY EYE PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Sex: M F

Date: _____ Occupation: _____

What is the main reason that you made an appointment for today? _____

Have you had any of the following conditions? (Check all that Apply)

<u>Problem</u>	<u>For how long?</u>	<u>Problem</u>	<u>For how long?</u>
<input type="checkbox"/> Eyes Feel Dry	_____	<input type="checkbox"/> Discharge from Eyes	_____
<input type="checkbox"/> Red/Infected Eyes	_____	<input type="checkbox"/> Itching	_____
<input type="checkbox"/> Feeling of Something in Eye	_____	<input type="checkbox"/> Sandy Feeling	_____
<input type="checkbox"/> Grittiness	_____	<input type="checkbox"/> Constant Tearing	_____
<input type="checkbox"/> Eyes Feel Tired	_____	<input type="checkbox"/> Irritation from Outside Air	_____
<input type="checkbox"/> Irritation from Swimming	_____	<input type="checkbox"/> Sensitivity to Light	_____
<input type="checkbox"/> Trouble Swallowing Food	_____	<input type="checkbox"/> Eyes Burn	_____
<input type="checkbox"/> Blurred Vision	_____	<input type="checkbox"/> Use Eye Drops	_____

Have you had any of the following? (Check all that Apply)

<u>Yes</u>	<u>Condition</u>	<u>Describe</u>
<input type="checkbox"/>	Eye Surgery	_____
<input type="checkbox"/>	Eye Injury	_____
<input type="checkbox"/>	Other Eye Problems	_____

Have your or any close relative had any of the following conditions? (Check all that Apply)

	<u>Yourself</u>	<u>Relative</u>		<u>Yourself</u>	<u>Relative</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other Systemic Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Describe	_____				

Have your eyes become dry since taking any of these medications? (Check all that Apply)

- | | |
|--|--|
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Diuretics (water pills) |
| <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Blood Pressure Pills |
| <input type="checkbox"/> Pills for acne | <input type="checkbox"/> Hormone Replacement Therapy |
| <input type="checkbox"/> Sleeping Tablets | <input type="checkbox"/> Other _____ |