EVERGREEN EYE CENTER
Leading-edge, patient-centered care.

DRY EYE QUESTIONNAIRE

Dry eye affects 20 percent of the population and can be caused by many different things. Some of these include age, gender, medical conditions, medications, environmental factors, long-term contact lens use, and surgeries on the surface of the eye. If the information provided in this form (combined with other clinical data) indicates Dry Eye Disease, your doctor may recommend that a Tear Osmolarity Test be performed in the future. This questionnaire will help your doctor to better determine your course of care and more accurately address your therapeutic needs.

Thank you!

Patient Name: _____ **(Staff to enter) Pt ID:** _____
Date of Birth: _____ **Today's Date:** _____

Symptoms (Circle yes for all that apply)

Burning/stinging	Yes	Blurred/fluctuating vision	Yes
Foreign body sensation	Yes	Dryness	Yes
Watering	Yes	Itching	Yes
Contact lens discomfort	Yes	Discharge/crusting	Yes

Use of any of the following: (Circle yes for all that apply)

Contact lenses	Yes	Eye drops for dry eyes, glaucoma, or allergies	Yes
Artificial tears	Yes		

Systemic Medical Conditions (Circle yes for all that apply)

Sjogren's Syndrome	Yes	Crohn's Disease	Yes
Thyroid disease	Yes	Rosacea	Yes
Lupus	Yes	Rheumatoid arthritis	Yes

Systemic Medications (Circle yes for all that apply)

Anti-depressants	Yes	Antihistamines	Yes
Hormone replacement therapy	Yes	Blood pressure medications	Yes

Environmental Factors (Please circle one option for each factor)

Work in dusty or dry environments	None	Low	Moderate	High	
Computer and cell phone use	None	Low	Moderate	High	
Seasonal allergies	None	Low	Moderate	High	
Air Conditioners/Heaters/Fire places	None	Low	Moderate	High	
Cigarette Smoker	None	Low	Moderate	High	Former

Tested Today: OD_____ **OS**_____