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)

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

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

Yes	Condition	Describe
☐	Eye Surgery	_____
☐	Eye Injury	_____
☐	Other Eye Problems	_____

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

	Yourself	Relative		Yourself	Relative
Glaucoma	☐	☐	Cataracts	☐	☐
Systemic Lupus	☐	☐	Heart Disease	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐
Other Systemic Disease	☐	☐			

Describe_____

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

☐ Antihistamines
☐ Oral Contraceptives
☐ Pills for acne
☐ Diuretics (water pills)
☐ Blood Pressure Pills
☐ Hormone Replacement Therapy

☐ Sleeping Tablets
☐ Other_____