OMEG
OKLAHOMA MEDICAL EYE GROUP

Patient Name: _____

Date: _____

DRY EYE DISEASE QUESTIONNAIRE

DRY EYE QUESTIONS

Do you think you have dry eye? ..... ☐ Yes ☐ No

Have you been diagnosed with dry eye? ..... ☐ Yes ☐ No

How often do you experience dryness? *Circle one*: **None** **Sometimes** **Frequently** **Always**

Do you have dry nasal passages or dry mouth? ..... ☐ Yes ☐ No

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 significant amount of crusting on your eyelids? ..... ☐ Yes ☐ No

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

Do you use artificial tears? ..... ☐ Yes ☐ No

***If yes*:** Typically how many artificial tear drops do you use *per day*?
☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ more than 4x/day

What type of artificial tears do you use?
☐ Oasis Tears ☐ Refresh Tears ☐ Systane ☐ Visine ☐ Fresh Kote ☐ Celluvisc
☐ Muro 128 Ointment ☐ TheraTears ☐ Other

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

Current or Previous dry eye treatments: ☐ Punctal Plugs ☐ Warm Compresses & Lid Scrubs ☐ Restasis

Contact Lens Wear? ..... ☐ Yes ☐ No

***If yes*:** Are you using contact lens rewetting drops? ☐ Yes ☐ No

***If yes*:** Type of drop and how often? _____

Number of comfortable wearing hours: _____

Do you have dry eye symptoms when not wearing lenses? ☐ Yes ☐ No

***If no*:** Were you previously a contact lens wearer that stopped due to difficulty or intolerance to contact lens wear? ☐ Yes ☐ No

SYMPTOMS – *Experienced over the past week*:

☐ Blurred vision
☐ Burning
☐ Decrease contact lens wear time
☐ Dry mouth
☐ Dryness
☐ Glare
☐ Grittiness
☐ Itching
☐ Light Sensitivity
☐ Night driving problems
☐ Ocular discomfort (aching)
☐ Redness
☐ Stinging
☐ Tearing

LIFESTYLE RISK FACTORS – *Check all that apply:*

☐ Over age 40
☐ Female
☐ Pregnant or Nursing
☐ Tobacco user
☐ A contact lens wearer
☐ Allergies
☐ Ocular Surgery - (*LASIK, PRK, Cataract Surgery*)
☐ Use a computer more than 1 hour per day
☐ Read more than 1 hour per day
☐ Travel by airplane more than twice per month
☐ Routinely use a ceiling fan in your bedroom
☐ Drink 3 or more caffeinated drinks per day (*Coffee, Tea, Pop*)
☐ Drink 3 or less glasses of water per day
☐ Lid Surgery - (*Blepharoplasty, Ptosis, Ectropion/Entropion Surgery*)

SYSTEMIC DISEASE RISK FACTORS – *Check all that apply:*

☐ Acne Rosacea
☐ Arthritis
☐ Diabetes
☐ Facial Herpes Zoster (*Shingles*)
☐ Lupus
☐ Multiple Sclerosis
☐ Sarcoid
☐ Sjogren's Syndrome
☐ Sleep Disorder/Sleep Apnea
☐ Thyroid Disease

MEDICATION RISK FACTORS – *Check all that apply:*

☐ Allergy Eye Drops
☐ Anti-depressants
☐ Antihistamines
☐ Beta Blockers
☐ Birth Control Pills
☐ Diuretics (LASIX, Water Pills)
☐ Fosamax
☐ Glaucoma Eye Drops
☐ Hormone Replacement Therapy
☐ Nasal Corticosteriods (*Flonase, Nasacort*)

Patient Name: _____

Date: _____ **BOTH EYES**

DRY EYE QUESTIONNAIRE - SPEED

Please answer the following questions by checking the box that best represents your answer. Select only one box per question.

1. Report the type of SYMPTOMS you experience and when they occur:

SYMPTOMS	AT THIS VISIT		WITHIN PAST 72 HOURS		WITHIN PAST 3 MONTHS	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never 1 = Sometimes 2 = Often 3 = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No problems
1 = Tolerable - *not perfect but not uncomfortable*
2 = Uncomfortable - *irritating but does not interfere with my day*
3 = Bothersome - *irritating and interferes with my day*
4 = Intolerable - *unable to perform daily tasks*

4. Do you use eye drops for lubrication? ☐ YES ☐ NO

If yes, how often? _____