Dry Eye Questionnaire

GRIFFIN EYE CENTER

Patient Name or ID _____ Date: _____

Have you been diagnosed with any of the following:

Dry Eyes Blepharitis Meibomian Gland Dysfunction Sjogrens Syndrome Rosacea

Do you have any of the following symptoms?

☐ Blurry vision
☐ Redness
☐ Burning
☐ Itching
☐ Foreign body sensation
☐ Scratchy feeling of sand of grit in the eye
☐ Crusting on Lashes
☐ Excess Tearing / watering eyes
☐ Tired eyes / eye fatigue
☐ Stringy mucus in or around eye
☐ Light sensitivity
☐ Contact lens discomfort
☐ Swollen Lids
☐ Loss of Lashes

Have you had any of the following surgeries?

Cataract: ☐ Y ☐ N Glaucoma: ☐ Y ☐ N Refractive: ☐ Y ☐ N

Do you ?

☐ Wear Contact lenses
☐ Have Punctal Plugs or have you ever had them
☐ Sleep under a ceiling fan or air vent
☐ Smoke

Please list all EYE drops that you use: _____

_____

Are you taking any of the following medications?

☐ Antihistamines/decongestants
☐ Oral corticosteroids
☐ Antihypertensive (e.g., diuretic, beta-blocker)
☐ Antidepressant or anti-anxiety
☐ Hormone replacement therapy or estrogen
☐ Accutane or other oral treatment for acne

Office use Only:

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has dry eye disease. I am ordering the following test to obtain a diagnosis and management of this patient's ocular problem(s).

Clinician: _____ Date: _____