PHILADELPHIA OPHTHALMOLOGY ASSOCIATES
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	_____		

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	☐	☐
Dry Mucous Membranes	☐	☐	Heart Disease	☐	☐
Systemic Lupus	☐	☐	Use Eye Drops	☐	☐
Other Systemic Disease	☐	☐			

Describe_____

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

☐Antihistamines	☐Diuretics (water pills)
☐Oral Contraceptives	☐Blood Pressure Pills
☐Sleeping Tablets	☐Other_____

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Patient Name: _____ Date: _____

How often do you have these eye problems?

a. Redness	□ Never	□ Rarely	□ Commonly	□ Always
b. Sandy-Gritty Feeling	□ Never	□ Rarely	□ Commonly	□ Always
c. Itching	□ Never	□ Rarely	□ Commonly	□ Always
d. Excess Watering	□ Never	□ Rarely	□ Commonly	□ Always
e. Burning	□ Never	□ Rarely	□ Commonly	□ Always
f. Excess Mucous	□ Never	□ Rarely	□ Commonly	□ Always
g. Blurry Vision (helped by blinking)	□ Never	□ Rarely	□ Commonly	□ Always

Are your eyes sensitive to these conditions?

a. Smoke	□ Never	□ Rarely	□ Commonly	□ Always
b. Light	□ Never	□ Rarely	□ Commonly	□ Always
c. Air Pollution	□ Never	□ Rarely	□ Commonly	□ Always
d. Wind	□ Never	□ Rarely	□ Commonly	□ Always
e. Computer Screens	□ Never	□ Rarely	□ Commonly	□ Always
f. Heaters	□ Never	□ Rarely	□ Commonly	□ Always
g. Air Conditioning	□ Never	□ Rarely	□ Commonly	□ Always
h. Contact Lenses	□ Never	□ Rarely	□ Commonly	□ Always

Do you have any of these problems?

a. Do you get eye strain?	□ No	□ Yes
b. Do you blink your eyes excessively?	□ No	□ Yes

NOTE: Other health conditions may contribute to dry eye. In addition, many medications can create dry eye symptoms.