TEAR & OCULAR SURFACE QUESTIONNAIRE - INITIAL EVALUATION

PATIENT NAME _____ DATE_____

Please answer the following questions by circling the correct answer where appropriate.

1. Sex Male Female
2. Age 20-35 36-45 46-55 56-65 66-90+
3. Do you feel like you have something in your eye, a sandy or gritty sensation? Never/Sometimes/Often/Constantly
   Does it feel better when you rub your eyes? Yes/No
   Do your eyes water whenever you get something in your eye? Never/Sometimes/Often/Constantly
4. Does your vision seem to fluctuate when you read? Never/Sometimes/Often/Constantly
5. Do you suffer from intermittent blurred vision? Never/Sometimes/Often/Constantly
   Does your blurred vision clear immediately after the blink and then blur again? Yes/No
6. Do your eyes feel sticky or stuck shut in the morning? Never/Sometimes/Often/Constantly
   Does washing your eyes seem to help them feel better? Yes/No
7. Do you suffer from frequent styes? Yes/No
8. Do your eyes tear or water excessively? Never/Sometimes/Often/Constantly
9. Did you ever take Accutane for an acne problem? Yes/No

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10. Have you been treated for dry eyes in the past? If so, what therapy was used and what were the results?
    _____
11. Do you currently use any type of artificial tear? Yes/No Name _____
    How long have they been used? _____ How often during the day? _____
12. Do your eyes burn? Never/Sometimes/Often/Constantly
    When does it start? _____ How long does it last?_____
13. Do your eyes get tired? Never/Sometimes/Often/Constantly
14. Do your eyes feel sore when blinking or moving your eyes? Never/Sometimes/Often/Constantly
15. Do you have sensitivity to bright lights or sunshine? Never/Sometimes/Often/Constantly
16. Are you sensitive to cigarette smoke? Never/Sometimes/Often/Constantly
17. Do you have increased dryness in AC or central heating? Never/Sometimes/Often/Constantly
18. Do your eyes feel scratchy? Never/Sometimes/Often/Constantly
19. Do your eyes feel sensitive to the wind? Never/Sometimes/Often/Constantly

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20. Do your eyes itch? Never/Sometimes/Often/Constantly
21. Are your lids usually red or puffy? Never/Sometimes/Often/Constantly
22. Do you have frequent eye infections? Yes/No
23. Do you have discharge from your eyes? Never/Sometimes/Often/Constantly
    Please describe the discharge _____
24. Have you ever had eyelid surgery? Yes/No
25. Have you ever had an injury to your eyes or eyelids? Yes/No

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26. Do you wear contact lenses? Yes/No
    Circle the type you wear RGP, Soft daily, soft extended wear
    How long do you wear them? _____ hrs/day How many years? _____ years
    Are your lenses comfortable? Yes/No
27. Are your eyes sensitive to the contact lens solution? Yes/No
28. Have you worn lenses before but quit wearing them due to discomfort? Yes/No

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29. Are you taking any prescription medications or over the counter medications including supplements and herbal remedies?
    Antihistamines Cold or Sinus Medication Diuretics (water pills)
    Birth control pills Hormone replacement Thyroid Medications Hypertension medications
    Tranquilizers Anti-anxiety medications Anti-depressants (tricyclic)
    Please list any other medications_____
    _____
30. Please list the names of the soaps, creams and makeup removers used around eyes:_____
    _____
31. Do you have any of the following: (Please Circle)
    Allergies – To What? _____Runny Nose Sneezing
    Asthma Thyroid Disorder Headaches
    Joint pain or arthritis Muscle Soreness Dry mouth or throat
    Chronic cough Nasal or sinus congestion
32. Have you every had any kind of ocular surgery including refractive surgery? Yes/No
    If yes, please specify surgery, which eye, when performed and surgeons name and city of practice
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33. My symptoms get worse when (please check all that apply): I'm tired____ In air conditioning____
    In a car with upper heating vents on____ During the winter____ When my allergies act up____