Dry Eye Questionnaire

Name: ________________________ Age:___________

Occupation: _____________________ Gender: Male Female

- Please answer the following questions by circling the appropriate answer:

  1. Have you been previously diagnosed with dry eye?
     - Yes (1) No (0)
  2. Do you believe you suffer from dry eye?
     - Yes (1) No (0)
  3. Are your dry eye symptoms worse in one eye?
     - Yes (1) No (0)
  4. Do you currently use eye drops to relieve any dry eyes?
     - Yes (1) No (0)
     - If yes, which brand of eye drops do you use? ________________________
     - How many times a day? ______________________
  5. How frequently do your eyes seem dry in a day?
     - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)

- **<u>Symptoms:</u>**

  1. Do you ever experience scratchiness or grittiness?
     - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
  2. Do you ever experience soreness?
     - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
  3. Do you ever experience burning?
     - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
  4. Do you ever experience red eyes?

- A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)

5. Do you every experience watery eyes?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
6. Do your eyes ever seem blurry, and then clear up after you blink?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
7. When your symptoms arise, do they seem to worsen as the day progresses?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
8. Do you have eye irritation as you wake from sleep?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)

- **Environmental Conditions:**

1. Are your eyes sensitive to cigarette smoke?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
2. Are your eyes sensitive to dry climates?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
3. Are your eyes sensitive to wind?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
4. Are your eyes sensitive to air pollution?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
5. Are your eyes sensitive to air-conditioning, heating, or defrost in a car?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
6. Are your eyes sensitive to dust?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)

7. Are your eyes sensitive to airplane flights?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
8. Do your eyes become irritated after swimming in chlorinated water (pools, hot tubs)?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
9. Do your eyes seem dry and irritated when drinking alcohol?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
10. Do your eyes seem dry and irritated the day after drinking alcohol?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)
11. Do your eyes seem to get dry during prolonged computer use?
    - A) never (0) B) seldom (1) C) sometimes (2) D) often (3) E) always (4)

- **General Eye Health**

1. Do you have any previous history of eye problems (trauma, infections, abnormalities)?
    - Yes (1) No (0)
    - If yes, please describe the eye problem:
      ______________________________________________________________

2. Are you known to sleep with your eyes partially open?
   - Yes (1) No (0) Sometimes (0.5)
3. Do you have allergies that affect your eyes?
   - Yes (1) No (0)
4. Are they seasonal allergies?
   - Yes (1) No (0)
5. Are they year-round allergies?
   - Yes (1) No (0)
6. Do you take antihistamines?
   - Yes (1) No (0)
7. Do you take any eye drops?
   - Yes (1) No (0) If yes, which one? _________________________

- **General Health**

1. Do you suffer from arthritis?
   - Yes (1) No (0) Uncertain (0.5)
2. Do you suffer from thyroid abnormalities?
   - Yes (1) No (0) Uncertain (0.5)
3. Do you suffer from dryness of the mouth, nose, or chest?
   - Yes (1) No (0) Uncertain (0.5)
4. Do you suffer from recurrent respiratory problems (bronchitis, pneumonia)?
   - Yes (1) No (0)
5. Do you suffer recurrent bladder infections and/or decreased vaginal secretions?
   - Yes (1) No (0)
6. Do you suffer from any skin abnormalities (seborrhea, rosacea, atopic dermatitis, eczema)?
   - Yes (1) No (0) If yes, which one? _________________________

7. Do you suffer from Parkinson's, Bell's Palsy, or Multiple Sclerosis?
    - Yes (1)    No (0)    If yes, which one? _________________________

8. Do you take any of the following medications? Please circle:
    - Birth Control Pills (1)
    - Diuretics (1)
    - Anti-hypertensives (1)
    - Sleeping tablets (1)
    - Ulcer Medication (1)
    - Digestive Medication (1)
    - Tranquilizers (1)
    - Hormonal supplements (1)

- **Contact Lenses:**

1. Do you currently wear contact lenses?
    - Yes (1)    No (0)
    - If yes, please continue. If no, please stop here.

2. Please indicate the type of lenses you wear:
    - Soft    Rigid gas permeable

3. Please indicate the replacement schedule of your current lenses:
    - Daily disposable (0)
    - Weekly (one, two, or three week interval) (1)
    - Monthly (one, two, or three month interval) (2)
    - Yearly (3)

4. Do you ever sleep in your contact lenses overnight?
    - Yes (1)    No (0)

5. Do you clean your contact lenses as indicated by packaging directions?

- Yes (1) No (0)

6. Do you clean your contact lenses every night?

   - Yes (1) No (0)

7. What solutions do you use? Please circle all that apply:

   - Aosept Boston Advance Complete Clear Care
   - Optifree Boston Original Renu Quick Care
   - Saline

8. Do you thoroughly rinse your lenses before insertion?

   - Yes (1) No (0)

9. Do your eyes burn or feel dry after removing your lenses?

   - Yes (1) No (0)

10. Do you experience dry eye sensations when wearing contact lenses?

    - Yes (1) No (0)
    - If yes, please answer the next question.

11. How long after inserting your lenses do your eyes become dry? ________________