DRY EYE DISEASE **QUESTIONNAIRE**

Patient Name or ID: _____ Date: _____

Technician: _____

Do you have any of the following symptoms?

- ☐ Dry eyes
- ☐ Blurry vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excess tearing/watering eyes
- ☐ Tired eyes, eye fatigue
- ☐ Stringy mucus in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand or grit in the eye

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ YES ☐ NO When? _____

If YES, is your appointment today to monitor dry eye treatment?

☐ YES ☐ NO

Are you here to be evaluated for:

- ☐ Cataract Surgery
- ☐ LASIK
- ☐ Other Surgery

Do you use?

- ☐ Contact lenses
- ☐ Over the counter eye drops such as artificial tears
- ☐ Eye drops for dry eye disease (e.g., Restasis*)
- ☐ Eye drops for glaucoma (e.g., latanoprost, Travatan*, Lumigan*)
- ☐ Eye drops for allergy (e.g., Pred Forte*, Pataday*)
- ☐ Nutritional supplements (e.g., omega-3)

Have you ever been diagnosed with any of the following:

- ☐ Sjogrens Syndrome
- ☐ Rosacea
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease

Have you ever had punctal plugs? ☐ YES ☐ NO

If the information provided in this form, in conjunction with other clinical data, raises the suspicion of Dry Eye Disease, then obtaining a Tear Osmolarity Test may be indicated. 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 and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician: _____ Date: _____

*Tradenames are the property of their respective owners.