advanced eyecare OF ARIZONA

for vision. for life. eyecare you can trust

Dry Eye Questionnaire

1. How often do you experience any of the following symptoms?

	NEVER	OCCASIONALLY	FREQUENTLY	CONSTANTLY
Redness				
Sandy or gritty sensation				
Itching				
Excess watering				
Burning				
Excess mucous or discharge				
Fluctuating/blurred vision (corrected with blinking)				

2. Are your eyes sensitive to these conditions?

	NEVER	OCCASIONALLY	FREQUENTLY	CONSTANTLY
Smoke				
Air pollutants				
Wind				
Computer glare				
Ait conditioning or heaters				
Contact lenses				
Light				

3. How often do you use the following medications?

	NEVER	RARELY	AS NEEDED	DAILY
Anti-depressants				
Antihistamines				
Decongestants				
Diuretics				
Beta Blockers				
Oral contraceptives				
Hormone replacement therapy				
Ulcer medication				
Incontinence medications				
Artificial tears (brand:)				
Redness reducing eye drops				

4. Have you ever been diagnosed with any of the following conditions?

	NO	YES
Thyroid problems		
Sleep disorders		
Arthritis		
Diabetes		
Sarcoidosis		
Herpes Zoster (Shingles)		
Systemic Lupus		
Rosacea		

	NO	YES
5. Are you over the age of 50?		
6. Are you post-menopausal?		
7. Do you blink excessively?		
8. Do you experience contact lens discomfort?		
9. Have you ever had refractive surgery (RK, PRK, LASIK, LASEK)?		

NAME: _____ **DATE:**_____ **CHART #:**_____