Patient Dry Eye Questionnaire

ROBERTS EYECARE ASSOCIATES

Name: _____ Date: _____

Place a check in the box that best describes your condition and enter the score in the score column.

How often do you have these eye problems?	Never 0	Sometimes 3	Frequently 4	Always 5	Score
Redness					
Sandy or Gritty Sensation					
Itching					
Excess Watering					
Burning					
Excess Mucous					
Blurred Vision (Corrected by Blinking)					
Are your eyes sensitive to these conditions?	**Never 0**	**Sometimes 2**	**Frequently 3**	**Always 4**	**Score**
Smoke					
Light					
Air Pollution					
Wind					
Computer Screens					
Heaters					
Air Conditioning					
Contact Lenses					
How often do you use these medications?	**Never 0**	**Sometimes 1**	**Frequently 2**	**Always 3**	**Score**
Anti-Depressants					
Redness Reducing eye Drops					
Decongestants					
Antihistamines					
Blood Pressure Medication					
Artificial Tears (lubricating drops)					
Hormones					
Oral Contraceptives					
Diuretics					
Ulcer Medications					
Tranquilizers					
Beta Blockers					
Have you been diagnosed with any of these conditions?		**Yes 2**	**No 0**		**Score**
Thyroid Abnormalities					
Rheumatoid Arthritis					
Asthma					
Diabetes					
Glaucoma					
Lupus					
		Yes 5	**No 0**		**Score**
Are you over 50 years of age?					
Are you post menopausal?					
Do you get eye strain?					
Do you blink excessively?					
Total the numbers in the score column. If you scored 30 or higher you may have dry eyes. Please call our office for an evaluation.					**TOTAL SCORE**