Cataract, Glaucoma & Retina
CONSULTANTS OF EAST TEXAS
Medical Arts Surgery Center | Benchmark Optical

DRY EYE QUESTIONNAIRE

PATIENT'S NAME OR ID: _____ **DATE:** _____

TECHNICIAN: _____

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

☐ Yes ☐ No When? _____

Do you have any of the following symptoms?

YES	NO		YES	NO	
☐	☐	Blurry vision	☐	☐	Excess tearing/watering eyes
☐	☐	Redness	☐	☐	Tired eyes, eye fatigue
☐	☐	Fluctuating vision	☐	☐	Stringy mucus in or around the eyes
☐	☐	Burning	☐	☐	Foreign body sensation, scratchiness in the eyes
☐	☐	Itching	☐	☐	Contact lens discomfort
☐	☐	Light sensitivity			

Have you had any of the following surgeries?

Cataract: ☐ Yes ☐ No Glaucoma: ☐ Yes ☐ No Refractive Surgery: ☐ Yes ☐ No

Do you use?

YES	NO	
☐	☐	Contact lenses
☐	☐	OTC eye drops such as artificial tears
☐	☐	Rx eye drops for Dry Eye Syndrome (e.g., Restasis*)
☐	☐	Rx eye drops for Glaucoma (e.g., Xalatan,* Timolol)
☐	☐	Rx eye drops for Allergy (e.g., anti-inflammatory, antihistamine)
☐	☐	Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

YES	NO	
☐	☐	Windy conditions
☐	☐	Places with low humidity (e.g., airplanes/hospital)
☐	☐	Areas that are air conditioned/heated

Are you taking any of the following medications?

YES	NO		YES	NO	
☐	☐	Antihistamines/decongestants	☐	☐	Hormone replacement therapy or estrogen
☐	☐	Antidepressant or anti-anxiety	☐	☐	Antihypertensives (e.g. diuretic, beta-blocker)
☐	☐	Oral corticosteroids	☐	☐	Accutane* or other oral treatment for acne

Have you ever had punctal occlusion?

☐ Yes ☐ No

It 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:** _____

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