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

OCULAR SURFACE HEALTH QUESTIONNAIRE

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

Do you have any of the following symptoms?

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

Have you used any eye drops in the last 2 hours?

☐ Yes ☐ No

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?

YES	NO	
☐	☐	Contact lenses
☐	☐	Over the counter eye drops such as artificial tears
☐	☐	Eye drops for dry eye disease (e.g., Restasis*, Xiidra*)
☐	☐	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:

YES	NO	
☐	☐	Sjogren's Syndrome
☐	☐	Rosacea
☐	☐	Multiple Sclerosis
☐	☐	Rheumatoid Arthritis
☐	☐	Thyroid Disease

Have you ever had punctal plugs?

☐ Yes ☐ No

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