Kapolei EYE CARE

DRY EYE QUESTIONNAIRE

Patient Name or ID: ______________________________ **Date:** ______________

Occupation: ______________________________ **Tech Initials:** _________

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease? ☐ YES ☐ NO

If yes, when were you diagnosed? ______________________________

Do you have any of the following symptoms?

- Blurry vision
- Redness
- Burning
- Itching
- Light sensitivity
- Excessive tearing/watering eyes
- Tired eyes
- Mucus/discharge in or around the eyes
- Foreign body sensation
- Contact lens discomfort
- Scratchy feeling of sand or grit in the eye
- Irritation from swimming
- Irritation from outside air

Have you had any of the following?

Eye Surgery ☐ YES ☐ NO **If yes, what kind?** ______________________________

Eye Injury ☐ YES ☐ NO **If yes, what kind?** ______________________________

Other Eye Problem ______________________________

Are your symptoms related to the following environmental conditions?

- Windy conditions
- Places with low humidity (e.g., airplanes/hospital)
- Areas that are air conditioned/heated

Have you or any close relatives had any of the following conditions? (Check all that apply)

	Yourself	Relative		Yourself	Relative
Glaucoma	☐	☐	Cataracts	☐	☐
Systemic Lupus	☐	☐	Heart Disease	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐
Other Systemic Disease	☐	☐			

Describe ______________________________

Have your eyes become dry since taking any of these medications? (Check all that apply)

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- **Antihistamines/decongestants**
- **Antidepressant or anti-anxiety**
- **Oral contraceptives**
- **Accutane or other oral treatment for acne**
- **Sleeping tablets**
- **Diuretics (water pills)**
- **Blood pressure pills**
- **Hormone replacement therapy or estrogen**
- **Other ______________________________**