THE POLYCLINIC

Dry Eye Questionnaire

Patient name: _____ MRN: _____

Your eye doctor requests dry eye testing to be done on both eyes for any patient that:

- Presents with dry eye symptoms
- Is undergoing therapy, or being monitored for dry eye disease
- Is a candidate for cataract or vision correction surgery

1. Please check if you have any of the following symptoms:
   - Dry eyes ___
   - Redness ___
   - Itching ___
   - Burning ___
   - Sandy/gritty feeling in the eye ___
   - Tired eyes ___
   - Fluctuation in vision ___
   - Light sensitivity ___
   - Watery eyes ___

2. On a scale of 1 to 10, how do you rate the **dryness** of your eyes?

No dryness 1 2 3 4 5 6 7 8 9 10

3. On a scale of 1 to 10, how do you rate the **irritation** of your eyes?

No irritation 1 2 3 4 5 6 7 8 9 10

4. How frequent are your symptoms? _____

5. How often are you using artificial over the counter tears? _____

6. Have you used any eye drops in the past 2 hours? YES NO

Dry Eye Testing

Test: InflammaDry: **Right eye**: Positive Negative **Left eye**: Positive Negative

Test: TearLab: **Right eye**: _____ **Left eye**: _____

Tech Initials: _____

Physician signature: _____ Date: _____