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: ______________

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