

DRY EYE DISEASE QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Many with dry eye disease do not have obvious symptoms. Please mark all the boxes in the following questionnaire that apply to you. Your answers will help us determine your risk for dry eye disease, including meibomian gland dysfunction (MGD).

Demographic Information (check all that apply)

- Over 50 years of age
- Post-menopausal
- Computer / tablet / TV / digital media use greater than 3 hours per day
- Contact lens wearer
- Frequent use of eye drops and/or artificial tears
- Have had eye surgery (LASIK, PRK, cataracts, or eyelid procedures)
- Poor night vision
- Use/used Restasis® or Xiidra®
- Have/had punctal plugs

If used, typically how many times per day do you use artificial tears?

- 3 or less
- 4 or more

Do you currently take any of the following medications? (check all that apply)

- Antihistamines
- Anti-depressants
- Diuretics
- Active bladder therapy
- Birth control pills
- Beta-blockers
- Hormone replacement therapy
- Radiation therapy
- Accutane (even previously)
- Glaucoma drops

Which of the following have you been diagnosed with? (check all that apply)

- Thyroid disease
- Arthritis
- Diabetes
- Glaucoma
- Lupus
- Rosacea
- Sleep disorders
- Sarcoidosis
- Facial Herpes Zoster (shingles)
- Hepatitis
- Androgen deficiency

Symptoms:

In the past week, which of the following symptoms have you experienced? (check all that apply)

- Stinging eyes
- Eye redness
- Blurred vision
- Frequent tearing
- Itchy eyes
- Light sensitivity
- Headaches
- Dry mouth
- Eye discomfort (aching)
- Eye irritation when wearing contact lenses
- Burning sensation in your eyes
- Eye dryness
- Eye grittiness
- Eye glare
- None