HEALTHY EYES
FAMILY VISION CARE

Dry Eye Questionnaire

Patient Name:_____**Date:**_____

Have you recently experienced any of the following with your eyes?

- ☐ Gritty or scratchy sensation?
- ☐ Redness?
- ☐ Burning?
- ☐ Itching?
- ☐ Watering?
- ☐ Excess Mucus?
- ☐ Pain or soreness?
- ☐ Blurred vision?

Are your eyes sensitive to any of the following conditions?

- ☐ Light?
- ☐ Computer screens?
- ☐ Wind?
- ☐ Heaters?
- ☐ Smoke?
- ☐ Contact lenses?

Do you take any of the following medication regularly?

- ☐ Anti-histamines
- ☐ Oral contraceptives/Hormones
- ☐ Decongestants
- ☐ Acne treatment
- ☐ Anti-depressants
- ☐ Blood pressure/Diuretics

Have you been diagnosed with any of these conditions?

- ☐ Rheumatoid arthritis
- ☐ Thyroid disease
- ☐ Lupus
- ☐ Diabetes
- ☐ Sjogren syndrome
- ☐ Sleep apnea

- ☐ Over the age of 50?
- ☐ Post-menopausal female?
- ☐ Sleep with ceiling or box fan going?
- ☐ History of laser eye surgery?