LAKELAND OPHTHALMOLOGY
973.331.0300
3799 Route 46 Parsippany, NJ 07054
RIGHT NEXT TO TGI FRIDAY'S

Name:_____

Dry Eye Disease/Ocular Surface Test Questionnaire

Have you used eye drops in the last 2-hours Y or N

Please circle the FREQUENCY of your dry eye symptoms

Dryness, Grittiness or Scratchiness	Never^0	Sometimes^1	Often^2	Constant^3
Soreness or Irritation	Never^0	Sometimes^1	Often^2	Constant^3
Burning or Watering	Never^0	Sometimes^1	Often^2	Constant^3
Eye Fatigue	Never^0	Sometimes^1	Often^2	Constant^3

Please circle the SEVERITY of your dry eye symptoms.

Dryness, Grittiness or Scratchiness	Never^0	Tolerable^1	Uncomfortable^2	Bothersome^3	Intolerable^4
Soreness or Irritation	Never^0	Tolerable^1	Uncomfortable^2	Bothersome^3	Intolerable^4
Burning or Watering	Never^0	Tolerable^1	Uncomfortable^2	Bothersome^3	Intolerable^4
Eye Fatigue	Never^0	Tolerable^1	Uncomfortable^2	Bothersome^3	Intolerable^4

Please circle if you have experienced these symptoms:

Today within the past 72 hours within the past 3 months

Do you use eye drops and/or ointments? Y or N Have you used them today? Y or N

Name of drops:_____ How long are they effective?_____

Do the drops last 4 hours? Y or N Do any gels last 12 hours? Y or N

Did you use Moisturizer, lotions or creams around eyes today? Y or N

Did you use makeup today? Y or N

Have you touched/rubbed your eye(s) today? If yes, when? How?

Have you ever been told you have BLEPHARITIS? Y or N STYE? Y or N

Do you have fluctuating vision problems (that gets better with BLINKING)?

Never Sometimes Frequently A lot / Always

For Office use only

TEAR LAB TESTING DONE? ***Y or N***