

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 before? 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)? _____

for office use only.
TEAR LAB TESTING DONE Y or N