LAKELAND OPHTHALMOLOGY

Parsippany NJ: 973.331.0300
Livingston NJ: 973.588.7005
www.eyedocnj.com

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.

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TEAR LAB TESTING DONE Y or N