INITIAL DRY EYE EVALUATION QUESTIONAIRE

DRY EYE CENTER at EAST MAIN VISION CLINIC

Full Name		**Date Of Birth**		**Today's Date**	

Dry eye is much more than just "dryness" or an insufficient production of tears. It is a very complex condition determined by the combination of multiple underlying issues affecting the tear film composition and ocular surface. Without taking the time and attention to determine the real causes, doctors and patients resort to a trial-and-error approach.

Today, we will do a comprehensive examination of everything that might affect the quality and quantity of your tears with our state-of-the-art equipment. We will work to determine what all is truly causing your symptoms and create a plan *together* to change the environment and stabilize your symptoms. The examination will be focused, and you will be told a lot of information. The key is not to panic, trust that everything will be written down for you to take home with you and trust the plan. Dry eye success requires dedication to the treatment course. Though there is no cure for dry eye, if you commit to the treatment plan, you will experience success!

Please thoughtfully answer the questions below. Your history is CRITICAL and provides us with a much better understanding of your condition, it's possible cause and how we can help.

1) How long have you had "eye" discomfort or "felt" your eyes?

2) Please list all dry eye products and treatments you have tried in the past.
Indicate with (*) what you are still using and how often:
(This will help Dr. Day qualify any new medications to your insurance company for the approval process).

3) Describe how your eyes feel: (i.e. burn, scratchy, painful, poking or stabbing sensation, etc.)

A)	If you wake in the middle of the night or when you first wake:	
B)	Midday:	
C)	Evenings:	

4) Please Describe:
How do you spend a typical day? (i.e. outdoors, reading, working, school, etc.)

Through your Day:

5)	Do you smoke?	
6)	Are you heavily exposed to secondhand smoke?	
7)	How many hours do you spend looking at any electronic device on average in a day?	
8)	Do you wear contact lenses?	
9)	Do you wear waterproof makeup? (eyeliner/mascara etc.)	

Thank you for your thoughtful answers

PLEASE CONTINUE TO THE NEXT PAGES

Please place an **X** in the field/answer that best describes your symptoms:

Symptom	Which Eye Is Worse?			Experienced on a daily basis?		Experienced on a weekly basis?		Experienced on a monthly basis?		Severity Level(1-10) 10 is terrible
	R	L	Both	Yes	No	Yes	No	Yes	No	1-10
Hard to open	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blink frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blink to see better	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Tearing	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Discharge	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Gritty	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Itching	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Redness	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Light sensitivity	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Eye pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	

OTHER SYMPTOMS, DURATION AND SEVERITY (1-10) **OTHER NEW OR UNDIAGNOSED SYMPTOMS:**

	Dry mouth	(mo/yr)			
	Unexplained fatigue	(mo/yr)			
	Joint Pain	(mo/yr)			

MEDICAL CONDITIONS ("X" ALL THE APPLY) Use blank spaces to enter anything additional

	Diabetes		Sjogren's		Chemo / Radiation
	Hypertension		Bells Palsy		Rheumatoid Arthritis
	Thyroid: Hyper / Hypo		Allergies / Hypersensitivity		Lupus / Fibromyalgia
	Hepatitis C		Rosacea / Dermatitis		Sarcoidosis
	Herpes: Simplex / Zoster		Sleep Disorders / C-PAP		Autoimmune Disease
	Depression				

MEDICATIONS CURRENT / PAST ("X" ALL THE APPLY) Use blank spaces to enter anything additional

	Diuretic		Accutane		Hormone Replacements
	Antihistamine		Botox injections		Oral Contraceptives
	Decongestant		Antidepressant / Antianxiety		Fish oil / Flaxseed oil

IRRITANTS and LIFESTYLE QUESTIONS ("X" ALL THAT APPLY) Use blank spaces to enter anything additional

	Reading		AC / Heat (home, work, car)		Ceiling fans
	Computer / device use		Wind		Department stores
	Contact lenses		Smoke		Work environment

WELL-BEING INDEX Hi Med Low

How many ounces of water do you drink daily?		Rank your exercise / activity level	
What else do you drink daily? Caffeine /Alcohol		Please rank your anxiety level	
How many times per month do you eat fish?		Please rank your stress level	
How many hours do you sleep per night avg.?		Are you depressed? (Y N Maybe)	
How many are uninterrupted hours of sleep?		How is your home environment?	

PLEASE CONTINUE TO THE NEXT PAGE:

Please Enter Any Physician Information that Applies:

Rheumatologist?	
Primary Care Doctor?	
Primary Eye Care Doctor?	
Who referred you to us?	

Please use the field below to add or explain any additional information you feel is pertinent to your upcoming visit that will better help us understand your symptoms.

Thank you for your time filling out this information. We look forward to seeing you soon.

Dr. Day and the Dry Eye Center Team