

DRY EYE QUESTIONNAIRE



Name _____ Date _____

Age _____ Sex M F Occupation _____

1. *Have you had any of the following issues? (Check all that apply)* None

- | | |
|---|--|
| <input type="checkbox"/> Eyes feel dry | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Discharge from eyes | <input type="checkbox"/> Constant tearing |
| <input type="checkbox"/> Red/irritated eyes | <input type="checkbox"/> Eyes feel tired |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Irritation from outside air |
| <input type="checkbox"/> Foreign body sensation | <input type="checkbox"/> Irritation from swimming |
| <input type="checkbox"/> Sandy feeling | <input type="checkbox"/> Trouble swallowing food |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Dry mucous membranes |

Describe _____

2. *Have you had any of the following ocular conditions? (Check all that apply)* None

- Eye surgery Eye injury Other eye problems

Describe _____

3. *Have you had any of the following conditions? (Check all that apply)* None

	Yourself	Relative
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Skin disorder/ rash	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus	<input type="checkbox"/>	<input type="checkbox"/>
Severe acne/ rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Other systemic disease	<input type="checkbox"/>	<input type="checkbox"/>

Describe _____

4. *Do your eyes become dry with any medications? (Check all that apply)* None

- | | |
|--|---|
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Blood pressure pills |
| <input type="checkbox"/> Diuretics (water pills) | <input type="checkbox"/> Sleeping tablets |
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Other _____ |

5. *Do you: (Check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Use a computer more than 2 hours a day? | <input type="checkbox"/> Drink more than 3 caffeinated (coffee, tea, cola) beverages per day? |
| <input type="checkbox"/> Read for more than 2 hours per day? | <input type="checkbox"/> Smoke? |
| <input type="checkbox"/> Use a fan at night? | |

6. *Have you ever been told that you are a MRSA carrier or have you ever had a MRSA infection?*

- Yes No Don't know

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

By signing below you:

- Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
- Acknowledge that you have access to a copy of these documents in the center.

Name of Patient (Please print): _____

Signature of Patient or Personal Representative

Date

If Personal Representative's signature appears above, please describe relationship to the Patient:

References Available on the Internet:

www.hospitalconnect.com/aha/about/pbillofrights.html

www.isrs.org

Other References:

International Society for Refractive Surgery Position Paper on Co-Management of Refractive Surgery Preoperative and Postoperative Care, 2001 available from www.isrs.org