EyeGen Vision Center
16845 Algonquin Street., Huntington Beach, CA 92649

DRY EYE QUESTIONNAIRE

Name: _____ Date: _____

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments to thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by using the numbering system below by marking the correct box with an "**X**":

0 = Never, 1 = Sometimes, 2 = Often, 3 = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your symptoms using the ratings list below by marking the correct box with an "**X**":

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness, or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark with an "**X**" if you have experienced any dry eye symptoms:

1) Today _____ 2) Within the past 72 hours _____ 3) Within the past 3 months _____

Do you use eye drops and/or ointment? Yes No Today? Yes No

If yes, which drops do you use? _____ Last 4 hours? Yes No

Any gels used in the last 12 hours? Yes No

Moisturizers, Lotions, and/or Facial Creams Used Today? Yes No

Have you touched/rubbed your eye(s) today? Yes No How long ago did you touch/rub them? _____

Make-up on today? Yes No

Have you been told that you have blepharitis or have you been treated for a stye?
Blepharitis Yes No
Stye Yes No

Do you have fluctuating vision problems? (That can be corrected with blinking)
Never Sometimes Frequently A Lot / Always

FOR OFFICE USE ONLY: Total Speed Score (Frequency + Severity) = _____