Patient: _____
Date: _____

Patient Dry Eye Questionnaire

✔ Circle the number that best describes your condition and enter the number in the score column.

How often do you have these eye problems?	Never	Sometime	Frequently	Always	Score
Redness	0	3	4	5	
Sandy or Gritty Sensation	0	4	5	6	
Itching	0	3	4	5	
Excess Watering	0	3	4	5	
Burning	0	4	5	6	
Excess Mucous	0	3	4	5	
Blurred Vision (Corrected by Blinking)	0	4	5	6	
Are your eyes sensitive to these conditions?	**Never**	**Sometime**	**Frequently**	**Always**	**Score**
Smoke	0	2	3	4	
Light	0	2	3	4	
Air Pollution	0	2	3	4	
Wind	0	2	3	4	
Computer Screens	0	2	3	4	
Air Conditioning/Heaters	0	2	3	4	
Contact Lenses	0	2	3	4	
How often do you use these medications?	**Never**	**Sometime**	**Frequently**	**Always**	**Score**
Anti-Depressants	0	1	2	3	
Redness Reducing Eye Drops	0	1	2	3	
Decongestants/Antihistamines	0	1	2	3	
Blood Pressure Medication	0	3	4	3	
Artifical Tears (Lubricating Drops)	0	1	2	3	
Hormones	0	1	2	3	
Oral Contraceptives	0	1	2	3	
Tranquilizers	0	1	2	3	
Beta Blockers	0	1	2	3	
Have you been diagnosed with any of these conditions?	**Yes**	**No**			**Score**
Thyroid Abnormalities	2	0			
Rheumatoid Arthritis	2	0			
Rosacea	2	0			
Diabetes	2	0			
Glaucoma	2	0			
Lupus	2	0			
	Yes	**No**			**Score**
Are you over 50 years of age?	5	0			
Are you post menopausal?	5	0			
Do you get eye strain?	4	0			
Do you blink your eyes excessively?	4	0			

Total the numbers in the score column. If your score was 25 or higher, or you suspect you may have Dry Eye Syndrome, call Gig Harbor Family Eyecare to schedule your Dry Eye Evaluation at (253) 853-8613.

Total Score _____