SYMPTOM ASSESSMENT

Dry Eye Questionnaire

Your answers help document the frequency and severity of your dry eye symptoms, their effect on daily activities, and their history. Answer for a TYPICAL WEEK over the past month unless a question asks otherwise. There are no right or wrong answers.

NAME * | DATE OF BIRTH * | DATE COMPLETED *

01 SYMPTOM FREQUENCY

How often have you experienced each of the following during a typical week? Mark one circle per row.

	NEVER (0)	RARELY (1)	SOMETIMES (2)	OFTEN (3)	CONSTANTLY (4)
Dryness, grittiness, or a sandy feeling	○	○	○	○	○
Burning or stinging	○	○	○	○	○
Feeling that something is in your eye	○	○	○	○	○
Redness	○	○	○	○	○
Excessive watering or tearing	○	○	○	○	○
Blurry vision that improves with blinking	○	○	○	○	○
Tired or heavy eyes	○	○	○	○	○
Sensitivity to light	○	○	○	○	○

02 SYMPTOM SEVERITY

When these symptoms occur, how severe are they at their worst? Mark one circle per row.

	NONE (0)	MILD (1)	MODERATE (2)	SEVERE (3)	VERY SEVERE (4)
Dryness, grittiness, or scratchiness	○	○	○	○	○
Burning, stinging, or soreness	○	○	○	○	○
Blurry or fluctuating vision	○	○	○	○	○
Eye fatigue or heaviness	○	○	○	○	○

03 IMPACT ON DAILY ACTIVITIES

How much difficulty do your eye symptoms cause with each activity? Mark one circle per row.

	NO DIFFICULTY (0)	SLIGHT (1)	MODERATE (2)	SEVERE (3)	UNABLE / AVOID (4)
Reading	○	○	○	○	○
Computer, phone, or tablet use	○	○	○	○	○
Driving at night	○	○	○	○	○
Watching television	○	○	○	○	○
Outdoor activities (wind, sun, cold)	○	○	○	○	○

04 HISTORY AND ONSET

WHICH EYE IS AFFECTED BY DRYNESS?

○ Right ○ Left ○ Both

APPROXIMATE DATE SYMPTOMS BEGAN (MONTH/YEAR)

WHAT DO YOU CONNECT YOUR SYMPTOMS TO?

WHEN DID YOUR DRY EYE SYMPTOMS BEGIN?

○ Before service ○ During service ○ After service

MY SYMPTOMS ARE WORSE IN THE FOLLOWING SITUATIONS (CHECK ALL THAT APPLY)

☐ Windy conditions
☐ Smoke, dust, or fumes
☐ First thing in the morning
☐ Dry air, heating, or air conditioning
☐ Prolonged screen use
☐ Late in the day or evening

05 EYE SURGERY HISTORY

HAVE YOU EVER HAD AN ELECTIVE EYE PROCEDURE, SUCH AS LASER EYE SURGERY (E.G., LASIK OR PRK)?

○ Yes ○ No

IF YES, WHICH EYE?

○ Right ○ Left ○ Both

NAME OR DESCRIPTION OF PROCEDURE

DATE(S) OF PROCEDURE

DID YOUR DRY EYE SYMPTOMS BEGIN OR WORSEN AFTER THE ELECTIVE PROCEDURE?

○ Began after ○ Worsened after ○ No change ○ Not applicable

HAVE YOU HAD ANY OTHER EYE SURGERY (E.G., CATARACT, EYELID, CORNEA, RETINA)?

○ Yes ○ No

NAME OR DESCRIPTION OF SURGERY

DATE(S) OF SURGERY

DID YOUR DRY EYE SYMPTOMS BEGIN OR WORSEN AFTER THAT SURGERY?

○ Began after ○ Worsened after ○ No change ○ Not applicable

06 TREATMENT HISTORY

INDICATE THE TYPES OF TREATMENT YOU HAVE USED FOR DRY EYE (CHECK ALL THAT APPLY)

- ☐ No treatment
- ☐ Over-the-counter artificial tear drops, gels, or ointments
- ☐ Prescription medications (e.g., Restasis, Xiidra, Cequa, Miebo)
- ☐ Special contact lenses (e.g., scleral or bandage lenses)
- ☐ Plugs to block the tear ducts through which tears drain (punctal plugs)
- ☐ Warm compresses, lid scrubs, or in-office gland treatment (e.g., LipiFlow, IPL)
- ☐ Surgical procedures for dry eye
- ☐ Other

IF SURGICAL OR OTHER: NAME OR DESCRIPTION

DATE(S)

ARTIFICIAL TEARS: TIMES USED PER DAY

BRANDS OR DROPS YOU HAVE TRIED

MEDICATIONS THAT MAY AFFECT DRY EYE

DO YOU CURRENTLY WEAR REGULAR CONTACT LENSES?

○ Yes ○ No ○ Stopped due to dryness

07 EFFECT ON VISION

DO YOU FEEL YOUR VISION HAS DECREASED OR BECOME IMPAIRED BECAUSE OF YOUR DRY EYE?

○ Yes ○ No ○ No decrease in vision

IF YES, DESCRIBE HOW YOUR VISION IS AFFECTED

WHICH DRY EYE PROBLEM DO YOU BELIEVE CAUSES IT?