Five Points Eye Care
"We've got our eyes on yours"

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Dry Eye Questionnaire

1. How often do you experience any of the following symptoms?				
	Never	**Occasionally**	**Frequently**	**Constantly**
Redness				
Sandy or gritty sensation				
Itching				
Excess watering				
Burning				
Excess mucous discharge				
Fluctuating/blurred vision (corrected with blinking)				

2. Are your eyes sensitive to these conditions?				
	Never	**Occasionally**	**Frequently**	**Constantly**
Smoke				
Air pollutants				
Wind				
Computer glare				
Air conditioning or heaters				
Contact lenses				
Light				

3. How often do you use the following medications?				
	Never	**Rarely**	**As Needed**	**Daily**
Anti-depressants				
Antihistamines				
Decongestants				
Diuretics				
Beta Blockers				
Oral contraceptives				
Hormone replacement therapy				
Ulcer medications				
Incontinence medications				
Artificial tears (brand:_____)				
Redness reducing eye drops				

4. Have you ever been diagnosed with any of the following conditions?				
	No	**Yes**		
Thyroid problems				
Sleep disorders				
Arthritis				
Diabetes				
Sarcoidosis				
Herpes Zoster (Shingles)				
Systemic Lupus				
Rosacea				

5. Are you over age 50?				
6. Are you post-menopausal?				
7. Do you blink excessively?				
8. Do you experience contact lens discomfort?				
9. Have you ever had refractive surgery? (RK, PRK, LASIK, LASEK)				

Name:_____ **Date:**_____ **Chart:**_____