# OCULAR SURFACE HEALTH **QUESTIONNAIRE**

Patient Name or ID: _____ Date: _____

Technician: _____

Do you have any of the following symptoms?

- ☐ Dry eyes
- ☐ Blurry vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Fluctuating Vision
- ☐ Excess tearing/watering eyes
- ☐ Tired eyes, eye fatigue
- ☐ Stringy mucus in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand or grit in the eye

Have you used any eye drops in the last 2 hours?

☐ YES ☐ NO

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ YES ☐ NO When? _____

If YES, is your appointment today to monitor dry eye treatment?

☐ YES ☐ NO

Are you here to be evaluated for:

- ☐ Cataract Surgery
- ☐ LASIK
- ☐ Other Surgery

Do you use?

- ☐ Contact lenses
- ☐ Over the counter eye drops such as artificial tears
- ☐ Eye drops for dry eye disease (e.g., Restasis*, Xiidra*)
- ☐ Eye drops for glaucoma (e.g., latanoprost, Travatan*, Lumigan*)
- ☐ Eye drops for allergy (e.g., Pred Forte*, Pataday*)
- ☐ Nutritional supplements (e.g., omega-3)

Have you ever been diagnosed with any of the following:

- ☐ Sjogrens Syndrome
- ☐ Rosacea
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease

Have you ever had punctal plugs?

☐ YES ☐ NO

**FOR OFFICE USE ONLY** - OSMOLARITY MEASUREMENTS

Doctor's Order Initials _____ Date _____

RIGHT EYE *(mOsms/L)* _____ LEFT EYE *(mOsms/L)* _____

Osmolarity ☐ Normal ☐ Abnormal

Schedule for Dry Eye Workup ☐ Yes ☐ No

*Tradenames are the property of their respective owners.