

Patient Record	
Number:	_____
Date	_____
Time	_____

DRY EYE QUESTIONNAIRE

Please fill in the blank or circle the answer that best describes you. Choose only one answer per question.

1. What is your age?

2. What is your gender?

1 Male

2 Female

3. Have you worn contact lenses in the past?

1 Yes

2 No

4. If you have worn contact lenses in the past, which of the following did you wear most recently?

	<u>Yes</u>	<u>No</u>	<u>Not Applicable</u>
a. Rigid gas permeable	1	2	0
b. Disposable (lenses replaced frequently)	1	2	0
c. Soft daily wear (lenses replaced after 1 year or longer)	1	2	0
d. Extended wear (lenses worn overnight)	1	2	0

5. If you have worn contact lenses in the past, how important was each of the following issues in your decision to stop wearing contact lenses?

	<u>Not at All Important</u>			<u>Very Important</u>	<u>Not Applicable</u>	
a. I never got used to the lenses	1	2	3	4	5	0
b. The lenses were uncomfortable all day	1	2	3	4	5	0
c. The lenses were most uncomfortable when first put in	1	2	3	4	5	0
d. The lenses became more uncomfortable later in the day	1	2	3	4	5	0
e. My eyes felt dry	1	2	3	4	5	0
f. The lenses felt scratchy and irritating	1	2	3	4	5	0
g. My vision was not clear enough	1	2	3	4	5	0
h. Wearing contact lenses was too much trouble	1	2	3	4	5	0
i. Other reason (please specify below)	1	2	3	4	5	0

6. Questions about **EYE DISCOMFORT**:

a. During a typical day in the past week, **how often** did your eyes feel discomfort?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

When your eyes felt discomfort, **how intense was this feeling of discomfort...**

b. Within the first two hours of getting up in the morning?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

c. At the end of the day, within two hours of going to bed?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

d. When your eyes felt discomfort, **how much did the discomfort bother you?**

- | | | | | | |
|-------------------------|-------------------------------|---|---|---|------------------------------|
| Never
<u>have it</u> | Not at All
<u>bothered</u> | | | | Extremely
<u>bothered</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

7. Questions about **EYE DRYNESS**:

a. During a typical day in the past week, **how often** did your eyes feel dry?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

When your eyes felt dry, **how intense was this feeling of dryness...**

b. Within the first two hours of getting up in the morning?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

c. At the end of the day, within two hours of going to bed?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

d. When your eyes felt dry, **how much did the dryness bother you?**

- | | | | | | |
|-------------------------|-------------------------------|---|---|---|------------------------------|
| Never
<u>have it</u> | Not at All
<u>bothered</u> | | | | Extremely
<u>bothered</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

8. Questions about **EYE GRITTIENESS AND SCRATCHINESS**:

a. During a typical day in the past week, **how often** did your eyes feel gritty and scratchy?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

When your eyes felt grittiness and scratchiness, **how intense was this feeling of grittiness and scratchiness...**

b. Within the first two hours of getting up in the morning?

Never <u>have it</u>	Not at All <u>Intense</u>				Very <u>Intense</u>
0	1	2	3	4	5

c. At the end of the day, within two hours of going to bed?

Never <u>have it</u>	Not at All <u>Intense</u>				Very <u>Intense</u>
0	1	2	3	4	5

d. When your eyes felt gritty and scratchy, **how much did the grittiness and scratchiness bother you?**

Never <u>have it</u>	Not at All <u>bothered</u>				Extremely <u>bothered</u>
0	1	2	3	4	5

9. Questions about **EYE BURNING AND STINGING**:

a. During a typical day in the past week, **how often** did your eyes feel burning and stinging?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

When your eyes felt burning and stinging, **how intense was this feeling burning and stinging ...**

b. Within the first two hours of getting up in the morning?

Never <u>have it</u>	Not at All <u>Intense</u>				Very <u>Intense</u>
0	1	2	3	4	5

c. At the end of the day, within two hours of going to bed?

Never <u>have it</u>	Not at All <u>Intense</u>				Very <u>Intense</u>
0	1	2	3	4	5

d. When your eyes felt burning and stinging, **how much did the burning and stinging bother you?**

Never <u>have it</u>	Not at All <u>bothered</u>				Extremely <u>bothered</u>
0	1	2	3	4	5

10. Questions about **TIRED EYES:**

a. During a typical day in the past week, **how often** did your eyes feel tired?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

When your eyes felt tired, **how intense was this feeling of tired eyes ...**

b. Within the first two hours of getting up in the morning?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

c. At the end of the day, within two hours of going to bed?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

d. When your eyes felt tired, **how much did the feeling of tired eyes bother you?**

- | | | | | | |
|-------------------------|-------------------------------|---|---|---|------------------------------|
| Never
<u>have it</u> | Not at All
<u>bothered</u> | | | | Extremely
<u>bothered</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

11. Questions about **CHANGEABLE, BLURRY VISION:**

a. During a typical day in the past week, **how often** did your vision change between clear and blurry or foggy?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

When your vision was blurry, **how noticeable was the changeable, blurry, or foggy vision ...**

b. Within the first two hours of getting up in the morning?

- | | | | | | |
|-------------------------|---------------------------------|---|---|---|---------------------------|
| Never
<u>have it</u> | Not at All
<u>Noticeable</u> | | | | Very
<u>Noticeable</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

c. At the end of the day, within two hours of going to bed?

- | | | | | | |
|-------------------------|------------------------------|---|---|---|------------------------|
| Never
<u>have it</u> | Not at All
<u>Intense</u> | | | | Very
<u>Intense</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

d. When your vision was blurry, **how much did the changeable, blurry or foggy vision bother you?**

- | | | | | | |
|-------------------------|-------------------------------|---|---|---|------------------------------|
| Never
<u>have it</u> | Not at All
<u>bothered</u> | | | | Extremely
<u>bothered</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

12. Question about **EYELID REDNESS:**

During a typical day in the past week, **how often** did your eyelid margins look red?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

13. Question about **WATERY EYES:**

During a typical day in the past week, **how often** did your eyes look or feel excessively watery?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

14. Question about **EYE MUCUS AND CRUSTING:**

During a typical day in the past week, **how often** was mucus or crusty material in or around your eyes?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

15. Question about **CLOSING YOUR EYES:**

During a typical day in the past week, **how often** did your eyes bother you so much that you wanted to close them?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

16. Questions about how much different **TYPES OF AIR QUALITY BOTHER YOUR EYES:**

a. a room with **cigarette smoke or smog?**

- | | | | | | |
|----------------|---------------|---|---|---|-------------|
| Never | Not | | | | Very |
| <u>have it</u> | <u>at all</u> | | | | <u>much</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

b. a building with the **central air conditioning or heating** turned on?

- | | | | | | |
|----------------|---------------|---|---|---|-------------|
| Never | Not | | | | Very |
| <u>have it</u> | <u>at all</u> | | | | <u>much</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

c. **shopping at the mall or shopping in retail or fabric stores?**

- | | | | | | |
|----------------|---------------|---|---|---|-------------|
| Never | Not | | | | Very |
| <u>have it</u> | <u>at all</u> | | | | <u>much</u> |
| 0 | 1 | 2 | 3 | 4 | 5 |

17. Question about **ARTIFICIAL TEAR USE:**

During a typical day in the past week, **how often** did you use artificial tears?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

18. Question about **DRYNESS OF THE NOSE, MOUTH, OR VAGINA:**

During a typical day in the past week, **how often** did you experience dryness of the nose, mouth, or vagina?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Frequently
- 4 Constantly

19. During a typical day in the past week, **how often did you use a computer?**

- 0 Never
- 1 1 to 2 hours
- 2 3 to 6 hours
- 3 More than 6 hours

20. Are you currently taking any of the following medications?

	<u>Yes</u>	<u>No</u>
a. Thyroid medications	1	2
b. Blood pressure medications	1	2
c. Diabetes medications	1	2
d. Diuretics	1	2
e. Arthritis medications	1	2
f. Heart condition medications	1	2
g. Depression medications	1	2
h. Ulcer medications	1	2
i. Oral contraceptives	1	2
j. Antibiotics for acne or other skin conditions.....	1	2
k. Hormone replacement therapy	1	2
l. Allergy medications.....	1	2

21. Have you been told you have dry eye(s)?

- 1 Yes
- 2 No

22. If you use any of the following treatments for dry eye, how much help do they provide?

	<u>No help</u>			<u>Complete</u>	<u>Do Not</u>	
	<u>At all</u>			<u>Relief</u>	<u>Use</u>	
a. Artificial tears	1	2	3	4	5	0
b. Lubricating ointments or gels	1	2	3	4	5	0
c. Warm compresses or eyelid scrubs	1	2	3	4	5	0
d. Punctal plugs or cauterization	1	2	3	4	5	0
e. Room humidifier	1	2	3	4	5	0
f. Other (please specify below).....	1	2	3	4	5	0

23. Do you think you have dry eye(s)?

- 1 Yes
- 2 No

THANK YOU VERY MUCH!