NEW EYES

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Dry Eye Screening Questionnaire

Thank you for making an appointment with New Eyes. Many patients with Dry Eye Syndrome do not realize that the problems they are having are due to dry eyes. Please fill out the following questionnaire so that we may fully evaluate the health of your eyes.

Name:_____ Date:_____

Please check the appropriate box

I experience the following symptoms:	Never	Seldom	Often	Constantly
Eyes have sandy, gritty feeling	☐	☐	☐	☐
Dry eye feeling	☐	☐	☐	☐
Burning eyes	☐	☐	☐	☐
Eye redness	☐	☐	☐	☐
Itchy eyes	☐	☐	☐	☐
Excess tearing or watery eyes	☐	☐	☐	☐
Mucous discharge	☐	☐	☐	☐
Eye pain	☐	☐	☐	☐
Variable blurred vision	☐	☐	☐	☐
Tired eyes	☐	☐	☐	☐
Contact lens discomfort	☐	☐	☐	☐

My eyes are sensitive to:	Never	Seldom	Often	Constantly
Air conditioning	☐	☐	☐	☐
Sunlight or bright lights	☐	☐	☐	☐
Smoke	☐	☐	☐	☐
Air pollution	☐	☐	☐	☐
Computer screens	☐	☐	☐	☐
Heaters	☐	☐	☐	☐
Wind	☐	☐	☐	☐

What have you been doing to relieve these symptoms (check all that apply)?

- ☐ Nothing
- ☐ Home remedies (like rinsing the eyes with water)
- ☐ Using over the counter dry eye drops – which brand? _____
- ☐ How effective are the eye drops?_____