

Ocular Surface Questionnaire

Patient Name: _____

Date: _____

1. Please check any that apply to you?

Are you:

Female?	?	Using a computer more than 1 hour a day? ___hrs	?
Pregnant or Nursing?	?	Reading for more than 1 hour per day?	?
A contact lens wearer?	?	Traveling in airplanes more than twice per month?	?
A Tobacco user?	?	Routinely using a ceiling fan in your bedroom?	?
Over age 40?	?	Less than 7 hours of sleep/night in an average week?	?

2. Approximately how many glasses of water do you drink **per day**? Less than 3 glasses ?
More than 3 glasses ?

3. How many servings of fish do you have per week? Less than 3 ?
More than 3 ?

4. Do you take Omega-3 supplements? Y or N

a. What brand? _____

5. Do you currently take any of the following medications? (Please check all that apply)

Antihistamines	?	Beta blockers	?
Anti-depressants	?	Hormone Replacement therapy	?
Diuretics (LASIX)	?	Radiation therapy	?
Active bladder therapy	?	Accutane (even previously)	?

6. Do you use any of the following eye drops? (Please check all that apply)

Glaucoma drops ? Allergy drops ? Restasis ? Anti-inflammatory ?

Artificial Tears ? Other _____

Symptoms

1. Over the past week, which of the following ocular symptoms have you experienced?

Stinging ? Tearing ? Itching ? Grittiness ? Burning ? Redness ? Occasional Dryness ? Glare ?

Decreased contact lens wearing time ? Blurred vision ? Light Sensitivity ? Dry mouth ?

Night driving problems ? Ocular Discomfort ?

2. Have you ever had eye surgery (LASIK, PRK, Cataract Surgery, other)?
Yes ? **(Please specify)** _____ No ?

Systemic Disease

1. Which of following conditions have you been diagnosed with? (check all that apply)

Thyroid disease ? Arthritis ? Diabetes ? Lupus ? Acne Rosacea ? Sleep disorders ? Sarcoidosis ?

Facial HerpesZoster (Shingles) ? HepatitisC ? AndrogenDeficiency ?

Other questions

Do you notice mattering on your eyelids when you wake in the morning Yes ? No ?

Are your eyelids swollen or red along the lash margins Yes ? No ?

Do you experience burning in the morning Yes ? No ?

Do you have a significant amount of crusting on your eyelids Yes ? No ?

Does your vision fluctuate from clear to blurry especially in the morning
(including after reading, watching TV, computer or driving) Yes ? No ?

Do you use or have you tried Artificial Tears? Yes ? No ?

Brand name of Artificial Tears: _____

When used, how long does/did the relief last after you instill a drop of artificial tears?

Less than 15 minutes ?

Less than 1 hour ?

More than 1 hour ?

When used, typically how many artificial tear drops do or did you use per day?

4 or more ?

3 or less ?