

Ocular Surface Questionnaire

Patient Name: _____

Date: _____

Demographic information

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?
Over age 40? A contact lens wearer?
A Tobacco user? Consume 4 or more caffeinated beverages per day?
Traveling in airplanes more than twice per month?
Routinely using a ceiling fan in your bedroom?
Getting less than 7 hours of sleep per night in an average week?

Approximately how many glasses of water do you drink **per day**?

3 or more

Less than 3

Approximately how many servings of fish do you eat **per week**?

3 or more

Less than 3

Do you take omega-3 supplements such as fish oil? Yes No Name
brand _____

2. How many medications (different pills) do you currently take?

3 or more

Less than 3

3. 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)
C-Pap Machine

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

- Glaucoma drops Allergy drops

Other _____

Symptoms

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

Stinging <input type="checkbox"/>	Tearing <input type="checkbox"/>	Itching <input type="checkbox"/>	Grittiness <input type="checkbox"/>	Burning <input type="checkbox"/>
Decreased contact lens wearing time <input type="checkbox"/>	Redness <input type="checkbox"/>	Occasional Blurred vision <input type="checkbox"/>	Dryness <input type="checkbox"/>	Glare <input type="checkbox"/>
Night driving problems <input type="checkbox"/>	Ocular Discomfort (aching) <input type="checkbox"/>	Light Sensitivity <input type="checkbox"/>	Dry mouth <input type="checkbox"/>	

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 <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Lupus <input type="checkbox"/>	Acne Rosacea <input type="checkbox"/>
Sleep disorders <input type="checkbox"/>	Sarcoidosis <input type="checkbox"/>	Facial Herpes Zoster (Shingles) <input type="checkbox"/>	Hepatitis C <input type="checkbox"/>	Androgen Deficiency <input type="checkbox"/>

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 <input type="checkbox"/>
Less than 1 hour <input type="checkbox"/>
More than 1 hour <input type="checkbox"/>

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

4 or more <input type="checkbox"/>
3 or less <input type="checkbox"/>