Dry Eye Questionnaire

Name: ______________________________ Date: ____________________

Please answer the following by circling the responses most appropriate to you.

Which category best describes you?

Male:	under 25 years	(0)	Female:	under 25 years	(0)
Male:	25-40 years	(1)	Female:	25-45 years	(2)
Male:	over 45 years	(3)	Female	over 45 years	(4)

Do you currently wear any contact lenses? Yes / No?

Have you ever used eye drops or other treatments for dry eye?

Yes (1) No (0) Uncertain (1)

Do you ever experience any of the following symptoms? (Circle all that apply)

Soreness (1) Scratchiness (1) Dryness (1) Grittiness (1)

How often do you have these symptoms?

Never (0) Sometimes (1) Often (2) Constantly (3)

Are your eyes unusually sensitive to cigarette smoke, smog, air conditioning or central heating?

Yes (2) No (0) Sometimes (1)

Do your eyes become very red & irritated when swimming?

N/A (0) Yes (2) No (0) Sometimes (1)

Are your eyes dry & irritated the day after drinking alcohol?

N/A (0) Yes (2) No (0) Sometimes (1)

Do you take: (Circle all that apply)

Antihistamine Tablets (1)	Sleeping Tablets (1)	Duodenal Ulcer Tablets (1)
Antihistamine Drops (1)	Tranquilisers (1)	Digestive Tablets (1)
Diuretics (1)	Oral Contraceptive (1)	Blood Pressure Tablets (1)

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Do you suffer from arthritis?

Yes (2) No (0) Uncertain (1)

Do you experience dryness of the nose, mouth, throat, or chest?

Never (0) Sometimes (1) Often (2) Constantly (3)

Do you suffer from thyroid abnormality?

Yes (2) No (0) Uncertain (1)

Are you known to sleep with your eyes partly open?

Yes (2) No (0) Sometimes (1)

Do you have eye irritation as you wake from sleep?

Yes (2) No (0) Sometimes (1)

TOTAL SCORE ____________________

Over 20 is indicative of dry eye.

Between 10 & 20 is suggestive of borderline dry eye disease.