

DRY EYE SYMPTOMS CHECKLIST

Patient Name _____ Date _____

Indicate symptoms or conditions you now experience, or have experienced during the last 12 months.

- | | | |
|-----------------------|-----------------------|-----------------------------------|
| Right | Left | |
| Eye | Eye | EYE SYMPTOMS |
| YES | YES | |
| <input type="radio"/> | <input type="radio"/> | Redness |
| <input type="radio"/> | <input type="radio"/> | Dry Eye Feeling |
| <input type="radio"/> | <input type="radio"/> | Sandy or Gritty Feeling |
| <input type="radio"/> | <input type="radio"/> | Itching |
| <input type="radio"/> | <input type="radio"/> | Burning |
| <input type="radio"/> | <input type="radio"/> | Foreign Body Sensation |
| <input type="radio"/> | <input type="radio"/> | Constant Tearing |
| <input type="radio"/> | <input type="radio"/> | Occasional Tearing |
| <input type="radio"/> | <input type="radio"/> | Watery Eyes |
| <input type="radio"/> | <input type="radio"/> | Light Sensitivity |
| <input type="radio"/> | <input type="radio"/> | Eye Pain or Soreness |
| <input type="radio"/> | <input type="radio"/> | Sties, chalazion |
| <input type="radio"/> | <input type="radio"/> | Fluctuating Visual Acuity |
| <input type="radio"/> | <input type="radio"/> | "Tired" Eyes |
| <input type="radio"/> | <input type="radio"/> | Contact Lens Discomfort |
| <input type="radio"/> | <input type="radio"/> | Contact Lens Solution Sensitivity |
| <input type="radio"/> | <input type="radio"/> | Mucous Discharge |

- SECONDARY SYMPTOMS
- YES
- Sinus Problems
 - Sleep Apnea
 - Snoring
 - Sneezing
 - Chronic Bronchitis
 - Allergy Symptoms
 - GERD
 - Chronic Cold Symptoms
 - Middle Ear Congestion
 - Heartburn or Indigestion
 - Dry Mouth or Throat
 - Headaches
 - Asthma Symptoms

List any non prescription medications, vitamins, or supplements you take:

Circle the items which you are sensitive to:

- Pets Air conditioning
- Heaters Blowers/Fans
- Sunshine Contact Lens Wear
- Smog Airplane Cabins
- Dust Computer Screens
- Wind Cigarette Smoke

- _____ How many glasses of water do you drink per day?
- _____ How many caffeinated drinks per day?
- _____ How many hours do you use a computer per day?

- YES
- Do you use lubricating drops? What brand? _____
 - Do you wear contact lenses? How often? _____
 - Are your contact comfortable? How many hours/day do you wear them? _____
 - Have you tried contacts before and quit? How many years have you worn contacts? _____
 - _____ Why? _____
 - Do you wear glasses? How many years have you worn glasses? _____
 - Have you ever had eye surgery or an injury? Describe : _____

Patient's Signature _____

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Mead EyeCare & EyeWear

For all Dry Eye Exams and Evaluations please do not wear contact lenses, make up, creams, moisturizers, hand lotion, etc. Also do not use eye drops for at least 12 hours before your visit.

Do not rub eyes for 7-10 days after punctal plug insertion. Normal eye symptoms may include plug awareness, slightly itchy, reflex tearing. Return to the office for follow up if you experience discomfort, irritation, redness, swelling, or discharge.

First Follow-up for Dry Eye Evaluation

Name _____ Date _____

Yes	No	
_____	_____	How many days did you use the artificial tears?
_____	_____	How many times per day did you use the artificial tears?
_____	_____	Have you noticed a decrease in your dry eye symptoms?
_____	_____	What brand of artificial tears/lubricating drops have you been using?
_____	_____	Were you able to wear your contact lenses for a longer period of time?

Please rate your symptoms after using artificial tears for 10 days. Use a scale of 1 (No improvement) to 5 (Much improved). Leave blank if you're not experiencing the symptom.

_____	Redness	_____	Light Sensitivity	_____	Itching
_____	Watering	_____	Contact Lens Discomfort	_____	Soreness
_____	Dryness	_____	Mucous Discharge	_____	Burning
_____	Grittiness	_____	Fluctuating Vision		
_____	Tearing	_____	Tired Eyes		

Second Follow Up

Date _____

Please rate the following symptoms since having punctal plugs inserted.
1 (No improvement at all) to 5 (very much improved)

_____	Redness	_____	Light Sensitivity	_____	Itching
_____	Watering	_____	Contact Lens Discomfort	_____	Soreness
_____	Dryness	_____	Mucous Discharge	_____	Burning
_____	Grittiness	_____	Fluctuating Vision		
_____	Tearing	_____	Tired Eyes		

Yes	No	
_____	_____	Have you been using artificial tears?
		If so, how many days/week? _____ How many times per day? _____
		What brand of artificial tears are you using? _____
_____	_____	Do you feel there has been an improvement in your overall eye comfort?
_____	_____	Are there activities that you can perform longer or more comfortably since having the punctal plugs inserted?