# DRY EYE SYMPTOMS CHECKLIST

**Patient Name____________________________**  
**Date_____________

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

<table>
<thead>
<tr>
<th>Right Eye</th>
<th>Left Eye</th>
<th><strong>EYE SYMPTOMS</strong></th>
<th><strong>SECONDARY SYMPTOMS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
<td>Redness</td>
<td>Sinus Problems</td>
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<tr>
<td></td>
<td></td>
<td>Dry Eye Feeling</td>
<td>Sleep Apnea</td>
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<td></td>
<td></td>
<td>Sandy or Gritty Feeling</td>
<td>Snoring</td>
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<tr>
<td></td>
<td></td>
<td>Itching</td>
<td>Sneezing</td>
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<tr>
<td></td>
<td></td>
<td>Burning</td>
<td>Chronic Bronchitis</td>
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<td></td>
<td></td>
<td>Foreign Body Sensation</td>
<td>Allergy Symptoms</td>
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<tr>
<td></td>
<td></td>
<td>Constant Tearing</td>
<td>GERD</td>
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<tr>
<td></td>
<td></td>
<td>Occasional Tearing</td>
<td>Chronic Cold Symptoms</td>
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<tr>
<td></td>
<td></td>
<td>Watery Eyes</td>
<td>Middle Ear Congestion</td>
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<tr>
<td></td>
<td></td>
<td>Light Sensitivity</td>
<td>Heartburn or Indigestion</td>
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<tr>
<td></td>
<td></td>
<td>Eye Pain or Soreness</td>
<td>Dry Mouth or Throat</td>
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<td></td>
<td></td>
<td>Sties, chalazion</td>
<td>Headaches</td>
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<td></td>
<td></td>
<td>Fluctuating Visual Acuity</td>
<td>Asthma Symptoms</td>
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<td></td>
<td></td>
<td>&quot;Tired&quot; Eyes</td>
<td></td>
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<td></td>
<td></td>
<td>Contact Lens Discomfort</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contact Lens Solution Sensitivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucous Discharge</td>
<td></td>
</tr>
</tbody>
</table>

**YES**

Circle the items which you are sensitive to:

- 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?

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

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

**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?___  
  How many years have you worn contacts?___
- Have you tried contacts before and quit?  
  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_________________________________________**  
**DRY EYE SYMPTOMS CHECKLIST**  
**Patient Name____________________________**  
**Date_____________**
Mead EyeCare & EyeWear

For all Dry Eye Exams and Evaluations please do not wear contact lenses, make up, creams, moisturizes, 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?