Carolina Vision Center

total score:

Name: _____, _____ Date: ___/___/_____
(Last) (First)

DOB: ___/___/_____ Sex: M F

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we would ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the FREQUENCY of dry eye checked symptoms you are experiencing as Never, Sometimes, Often or Constant using the numbering system below:

SYMPTOMS	0 = never	1= sometimes	2= often	3= constant
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the SEVERITY of your Symptoms using the rating list below:

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

SYMPTOMS	0 = no problems	1 = tolerable	2 = uncomfortable	3 = bothersome	4 = intolerable
Dryness, Grittiness, or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark with an X if you have experienced symptoms:
1) Today_____ 2) Within the last past 72 hours_____ 3) Within past 3 months_____

Do you use eye drops and/or ointment?		YES	NO	
If yes, which drops do you use?	_____			
Have you been told that you have blepharitis?		YES	NO	
Have you been treated for a stye?		YES	NO	
Do you have fluctuating vision problems that can be corrected with blinking?	Never	Sometimes	Frequently	A Lot / Always