IC Laser Eye Care

Dry Eye Patient Questionnaire

Name:_____ Age:_____ Sex: ____M ___F

Date:_____ Occupation:_____

What is the main reason that you made you appointment today?_____
_____

Have you had any of the following conditions? (Check all that Apply)

_____Discharge from eye
_____Red/Infected Eyes

_____Eyes feel tired
_____Sandy feeling/something in eye

_____Sensitivity to light
_____Constant tearing

_____Itching
_____Grittiness

_____Blurred vision
_____Irritation from outside

_____Eyes Burn
_____Eyes feel dry

Have you had any of the following?

Yes	**Condition**	**Describe**
____	Eye Surgery	_____
____	Eye Injury	_____
_____	Other Eye Problems	_____

Have you or any close relative had any of the following conditions?

Condition	**You**	**Relative**	**Condition**	**You**	**Relative**
Glaucoma	____	_____	Cataracts	____	_____
Lupus	____	_____	Heart Disease	____	_____
Arthritis	____	_____	Diabetes	____	_____

Other Systemic Disease
Describe_____

Have your eyes become dry since taking any of these medications?

_____Antihistamines
_____Oral Contraceptives
_____Pills for acne
_____Sleeping pills

_____Diuretics(water pill)
_____Blood Pressure pill
_____Hormone replacement therapy
_____Other?_____

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