

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 | _____ Itching |
| _____ Red/Infected Eyes | _____ Grittiness |
| _____ Eyes feel tired | _____ Blurred vision |
| _____ Sandy feeling/something in eye | _____ Irritation from outside |
| _____ Sensitivity to light | _____ Eyes Burn |
| _____ Constant tearing | _____ Eyes feel dry |

Have you had any of the following?

<u>Yes</u>	<u>Condition</u>	<u>Describe</u>
_____	Eye Surgery	_____
_____	Eye Injury	_____
_____	Other Eye Problems	_____

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

<u>Condition</u>	<u>You</u>	<u>Relative</u>	<u>Condition</u>	<u>You</u>	<u>Relative</u>
Glaucoma	_____	_____	Cataracts	_____	_____
Lupus	_____	_____	Heart Disease	_____	_____
Arthritis	_____	_____	Diabetes	_____	_____
Other Systemic Disease					
Describe	_____				

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

- | | |
|---------------------------|-----------------------------------|
| _____ Antihistamines | _____ Diuretics(water pill) |
| _____ Oral Contraceptives | _____ Blood Pressure pill |
| _____ Pills for acne | _____ Hormone replacement therapy |
| _____ Sleeping pills | _____ Other? _____ |

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