



Ocular Surface Questionnaire

Patient Name: _____

Date: _____

Demographic Information:

1. Please check any that apply: **Are you?**

- | | | | |
|---|--------------------------|--|------------------------------------|
| Female? | <input type="checkbox"/> | Using a computer more than 1 hour a day? | <input type="checkbox"/> _____ hrs |
| Pregnant or Nursing? | <input type="checkbox"/> | Reading for more than 1 hour per day? | <input type="checkbox"/> |
| Over age 40? | <input type="checkbox"/> | A contact lens wearer? | <input type="checkbox"/> |
| A Tobacco user? | <input type="checkbox"/> | | |
| Traveling in airplanes more than twice per month? | <input type="checkbox"/> | | |
| Routinely using a ceiling fan in your bedroom? | <input type="checkbox"/> | | |
| Drinking more than 3 caffeinated (coffee, tea or colas) drinks per day? | <input type="checkbox"/> | | |
| Getting less than 7 hours of sleep per night in an average week? | <input type="checkbox"/> | | |

Approximately how many glasses of water do you drink **per day**?

Less than 3

3 or more

Approximately how many servings of fish do you eat **per week**?

Less than 3

3 or more

2. How many medications (different pills) do you currently take?

Less than 3

3 or more

3. Do you currently take any of the following medications? (**Please check all that apply**)

- | | | | |
|---------------------|--------------------------|-----------------------------|--------------------------|
| Birth control pills | <input type="checkbox"/> | Antihistamines | <input type="checkbox"/> |
| Beta blockers | <input type="checkbox"/> | Anti-depressants | <input type="checkbox"/> |
| Diuretics (LASIX) | <input type="checkbox"/> | Hormone Replacement therapy | <input type="checkbox"/> |

4. Do you use any of the following eye drops? (**Please check all that apply**)

- Glaucoma drops
- Allergy drops

Other _____

Symptoms:

1. Over the past week, which of the following ocular symptoms have you experienced?
(Please check all that apply)

<input type="checkbox"/> Stinging	<input type="checkbox"/> Tearing	<input type="checkbox"/> Ocular Discomfort (aching)	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Itching
<input type="checkbox"/> Decreased contact lens wearing time	<input type="checkbox"/> Burning	<input type="checkbox"/> Dryness	<input type="checkbox"/> Redness	<input type="checkbox"/> Glare
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Occasional blurred vision	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Night driving problems	

2. Have you ever had eye surgery (LASIK, PRK, Cataract Surgery, other)?
Yes **(Please Specify)** _____
No

Systemic Disease:

Which of the following conditions have you been diagnosed with? **(Please check all that apply)**

<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lupus	<input type="checkbox"/> Acne Rosacea
<input type="checkbox"/> Sleep disorders	<input type="checkbox"/> Sarcoid	<input type="checkbox"/> Facial Herpes Zoster (Shingles)	<input type="checkbox"/> MS	

Other Questions:

Do you notice mattering on your eyelids when you wake in the morning? Yes No
Are your eyelids swollen or red along the lash margins? Yes No
Do you have a significant amount of crusting on your eyelids? Yes No
Does your vision fluctuate from clear to blurry throughout the day?
(including after reading, watching TV, computer or driving) Yes No

Do you use artificial Tears? Yes No If yes, what is the Brand Name? _____

If yes, how long does the relief last after you instill a drop of artificial tears?

<input type="checkbox"/> Less than 15 minutes
<input type="checkbox"/> Less than 1 hour
<input type="checkbox"/> More than 1 hour

If yes, typically how many artificial tear drops do you use per day?

<input type="checkbox"/> 3 or less
<input type="checkbox"/> 4 or more

Call to schedule your appointment today!

Natalie Li, O.D., Keith Wan, O.D., Jay Mashouf, O.D.