Scripps Poway
EYECARE

Ocular Surface Questionnaire

Patient Name: _____

Date: _____

Demographic Information:

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

Female?	☐	Using a computer more than 1 hour a day?	☐ _____ hrs
Pregnant or Nursing?	☐	Reading for more than 1 hour per day?	☐
Over age 40?	☐	A contact lens wearer?	☐
A Tobacco user?	☐		

Traveling in airplanes more than twice per month? ☐
Routinely using a ceiling fan in your bedroom? ☐
Drinking more than 3 caffeinated (coffee, tea or colas) drinks per day? ☐
Getting less than 7 hours of sleep per night in an average week? ☐

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	☐	Antihistamines	☐
Beta blockers	☐	Anti-depressants	☐
Diuretics (LASIX)	☐	Hormone Replacement therapy	☐

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)

☐ **Stinging**	☐ **Tearing**	☐ **Ocular Discomfort (aching)**	☐ **Grittiness**	☐ **Itching**
☐ **Decreased contact lens wearing time**	☐ **Burning**	☐ **Dryness**	☐ **Redness**	☐ **Glare**
☐ **Light Sensitivity**	☐ **Occasional blurred vision**	☐ **Dry Mouth**	☐ **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**)

☐ **Thyroid disease**	☐ **Arthritis**	☐ **Diabetes**	☐ **Lupus**	☐ **Acne Rosacea**
☐ **Sleep disorders**	☐ **Sarcoid**	☐ **Facial Herpes Zoster (Shingles)**	☐ **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?
☐ **Less than 15 minutes**
☐ **Less than 1 hour**
☐ **More than 1 hour**

If yes, typically how many artificial tear drops do you use per day?
☐ **3 or less**
☐ **4 or more**