

DRY EYE SYMPTOMS CHECKLIST

NAME (Please Print): _____ **AGE:** _____

PLEASE CHECK THE SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING:

- | | |
|--|---|
| <input type="checkbox"/> Burning Eyes | Related Conditions: |
| <input type="checkbox"/> Sandy or Gritty Feeling | <input type="checkbox"/> Allergies or Hay Fever |
| <input type="checkbox"/> Constant Tearing | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Watering Eyes | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Eye Pain or Soreness | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Mucus Discharge | <input type="checkbox"/> Dry Throat or Mouth |
| <input type="checkbox"/> Blurry or Fluctuating Vision | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Lid Infections | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Discomfort with Bright Lights | <input type="checkbox"/> Joint/Arthritis Pain |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Dryness of the Eye | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> "Tired Eyes" | <input type="checkbox"/> Runny Nose |

PLEASE CHECK IF APPLICABLE:

- Do you use lubricating eye drops or artificial tears? Brand _____
- Do you frequently use a video terminal or computer monitor?
- Do you take any prescription or non-prescription drugs? Please List _____

ARE YOUR EYES SENSITIVE TO:

- | | |
|--|--|
| <input type="checkbox"/> Air Conditioning | <input type="checkbox"/> Tobacco Smoke |
| <input type="checkbox"/> Contact Lens Wear | <input type="checkbox"/> Dust |
| <input type="checkbox"/> Heaters | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Smog | <input type="checkbox"/> Wind |

CONTACT LENS USAGE:

- Have you ever worn contact lenses? Yes No If YES, please answer the following questions:
- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently wear contact lenses? How long have you worn them? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are they comfortable? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your eyes sensitive to contact lens solution? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you worn contact lenses before, and then quit for some reason? If so, what factors caused you to quit wearing them? _____ |

HAVE YOU OR A BLOOD RELATIVE EVER HAD:

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sjogren's Syndrome |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Lupus |

SIGNATURE: _____ **DATE:** _____