

Symptoms Checklist

Name (Please print): _____

Please check all of the symptoms you are currently experiencing.

- Burning eyes
- Sandy or gritty feeling
- Itching
- Dryness of the eyes
- Watering eyes
- Sensation of foreign matter in eyes
- "Tired eyes"
- Constant or occasional tearing
- Lid infection
- Discomfort with bright lights
- Redness
- Light sensitivity
- Eye pain or soreness
- Stringy mucus in or around the eyes
- Fluctuating vision

Related Conditions:

- Allergies or hay fever
- Asthma
- Bronchitis
- Chronic cough
- Dry throat or mouth
- Sneezing
- Headaches
- Middle ear congestion
- Joint/arthritis pain
- Nasal or sinus congestion
- Post-nasal drip
- Runny nose

Do you use any type of lubricating eye drops or artificial tears? _____

Do you have seasonal allergies? _____

Do you use eye drops for the treatment of glaucoma? _____

Are your eyes sensitive to:
(Please circle all choices that apply.)

air conditioning
dust
pollen
tobacco smoke
wind

contact lens wear
heaters
smog
video display terminals

If you wear contact lenses or have worn contact lenses in the past, please answer the following questions:

Yes No

- Do you currently wear contact lenses?
If so, how long have you worn them? _____ years
- Are they comfortable throughout the day?
- Are your eyes sensitive to contact lens solution?
- Have you worn contact lenses before, and then quit for some reason?

If so, what caused you to quit wearing them? _____

Signature: _____ Date: _____