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
☐ contact lens wear
☐ heaters
☐ smog
☐ video display terminals
☐ wind

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:___________________