Dry Eye Questionnaire

Name:_____ Date:___/___/___

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – Irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Does your face flush after drinking alcohol or exercising? Yes No (Circle)

Do you have trouble seeing at night while driving? Yes No (Circle)

For office use only
Total score (Frequency + Severity) = _____/28