Ocular Surface Health **Questionnaire**

! Complete at home and either email or bring a printed copy to the clinic

NAME ______________________________

Check all symptoms experienced since last visit.

- ☐ Dry Eyes
- ☐ Fluctuating Vision
- ☐ Blurry Vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excessive tearing/watery eyes
- ☐ Tired eyes/eye fatigue
- ☐ Stringy mucous in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy, feeling of sand or grit in eye

! Complete at the doctor's office

Has the patient received dry eye treatment in the past? ☐ Yes ☐ No

Has the patient used any eye drops in the last 2 hours? ☐ Yes ☐ No

FOR OFFICE USE ONLY Doctor's Order Initials ______________ Date ______________

Osmolarity Measurements

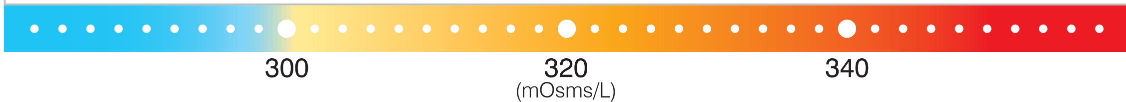
Right Eye (OD) ______________ *(mOsms/L)* Left Eye (OS) ______________ *(mOsms/L)*

Inter-eye difference is > 8mOsm/L ☐ Yes ☐ No

Osmolarity ☐ Normal ☐ Abnormal

Patient Dry Eye Severity ☐ Mild ☐ Moderate ☐ Severe

Schedule for Dry Eye Workup ☐ Yes ☐ No



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