Dry Eye Questionnaire

Date_____

Total Score_____/ 24

Name_____DOB_____

How Do Your Eyes Feel?

Check the *Symptoms* you suffer from :

On a scale of 0-4 report the ***SEVERITY*** USING THE RATING LIST BELOW:

0= No Problem

1= Tolerable- not perfect but not uncomfortable

2= Uncomfortable- irritating but does not interfere with my day

3= Bothersome- Irritating and interferes with my day

4= Intolerable- unable to perform my daily tasks

Symptoms of Dryness	**0**	**1**	**2**	**3**	**4**
Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Stinging					
Eye Fatigue (tired eyes**)**					
Watering or tears up excessively					
Itching					

Do you use eye drops for Lubrication? ☐ Yes ☐ No

If yes, How often? _____