APPLE HILL EYE CENTER

Dry Eye Questionnaire **Patient Name:**_____

1. Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?	___Yes ___No	When?_____
2. Are you currently using any over the counter or prescribed eye drops?	___Yes ___No	List name and dosage: _____ _____
3. Have you had any of the following eye related surgeries? Check all that apply.	___Yes ___No	___Cataract ___Corneal Transplant ___Glaucoma ___Refractive/ Lasik Other:_____
4. Do you have any of the following symptoms? Check all that apply.	___Yes ___No	___ Blurry vision ___Excessive tearing/watering ___Rednes ___Tired or fatigued eyes ___Burning ___Stringy mucus in/around eyes ___Itching ___Pressure Feeling ___Light Sensitivity ___Discomfort with contact ___Scratchy/Sandy Feeling lenses
5. Have you eyes felt uncomfortable in any of the following situations over the last week?	___Yes ___No	___Windy conditions ___Prolonged reading ___Sun exposure ___Prolonged Computer use ___Areas that are air conditioned/heated ___Places with low humidity ___Watching TV
6. Are you taking any of the following medications? Check all that apply.	___Yes ___No	___Oral contraceptives ___Accutane for acne ___oral Cortico-steriods ___Hormone replacements ___Anti-histamines ___Anti-depressants/anxiety ___Decongestants ___Anti-hypertensives
7. Do you suffer from any of the following? Check all that apply.	___Yes ___No	___Thyroid abnormalities ___Sjogrens Syndrome ___Acne/Rosacea ___Lupus ___Rhuematoid Arthritis ___Sleep Apnea- If yes, do you use a CPAP machine? ___Yes ___No
8. Are you known to sleep with you eyes partially open?	___Yes ___No	Comments?_____ _____

Patient Signature:_____**Date**:_____

If the patient answered "yes" to questions 2 or 3 and/or checked any of the boxes related to disease, and performing the InflammaDry test may be indicated.

If the patient checked off any of the boxes under question 4, then the information provided in this form, in conjuntion with other clinical data, raises the suspicion of dry eye disease, and performing the Tear Lab Test may be indicated.

I reviewed this form, and based on the information contained herein and other clinical data, I suspect that this patient has dry eye disease. Therefore, performing an InflammaDry or Tear Lab test to determine the presence of elevated MMP-9 or Osmolarity in tears is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Doctors Signature:_____ **Date:** _____