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## Dry Eye Questionnaire

Thank you for making an appointment with our office. Please fill out this questionnaire carefully. **Return it via email (as an attachment), fax, mail** or to my **receptionist** on the day of your appointment.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1) Please place a  $\checkmark$  in the appropriate box:

<b>I experience the following symptoms:</b>	Never	Seldom	Often	Always
Eyes have sandy, gritty feeling				
Itchy eyes				
Burning eyes				
Eye redness				
Excess tearing or watery eyes				
Mucous discharge				
Eye pain				
Variable blurred vision helped by blinking				

<b>My eyes are sensitive to:</b>	Never	Seldom	Often	Always
Smoke				
Light				
Air Pollution				
Wind				
Computer screens				
Heaters				
Air conditioning				
Contact lenses				

<b>How often do you use these medicines?</b>	Never	Seldom	Often	Always
Anti-depressants				
Antihistamines				
Artificial tears				
Beta blockers				
Blood pressure medicine				
Decongestants				
Diuretics				
Hormones				
Oral contraceptives				
Redness reducing eye drops				
Tranquilizers				
Ulcer medication				

2) What have you been doing for these symptoms up to now (check  $\checkmark$  all that apply)

- Nothing
- Home remedies (like rinsing your eyes with water)
- Using over the counter dry eye drops: \_\_\_\_\_  
 How effective are the drops? \_\_\_\_\_