EyeCare™ Specialties

(This box for office use only)
Patient # ____________
Total Score: ____________

Patient Information

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________ Gender: ☐ Male ☐ Female

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Frequency

Report the FREQUENCY of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or Constant using the numbering system below:

0 = Never, 1 = Sometimes, 2 = Often, 3 = Constant

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Severity

Report the SEVERITY of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or Constant using the numbering system below:

0 = No problems
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	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Additional Information

Have you experienced symptoms: ☐ 1.) Today ☐ 2.)Within the past 72 hours ☐ 3.) Within the past 3 months

Do you use eye drops and/or ointment? ☐ Yes ☐ No If yes, today? What time? ☐ Yes ☐ No Time: ____________

If yes, which drops do you use? ______________ How long are they affective? ____________

Have you used any drops within the past 4 hours? ☐ Yes ☐ No Any gel based drops within the past 12 hours? ☐ Yes ☐ No

How long did they last? ________ Used any moisturizers, lotions or facial creams today? ☐ Yes ☐ No

Have you touched or rubbed your eyes today? ☐ Yes ☐ No If so, when & how? ______________

Are you wearing make up today? ☐ Yes ☐ No Do you take Omega 3's? ☐ Yes ☐ No Ever had punctal plugs? ☐ Yes ☐ No

Have you been told that you have blepharitis or have you been treated for a stye? ☐ Yes ☐ No

Do you have fluctuating vision problems? (That can be corrected with blinking) ☐ Never ☐ Sometimes ☐ Frequently ☐ A Lot/Always

INSTRUCTIONS FOR DAY OF LIPIVIEW TESTING

1. No eye gels the night before or the day of testing
2. No dry eye drops the day of testing
3. No eye medications less than two hours before testing (i.e. Glaucoma Medications)
4. No contact lens wear the day of testing, OK after testing
5. No eye make up, facial moisturizers, lotions before testing, or the day of testing
6. No direct rubbing or touching your eyes two hours before testing