Name_____ DOB_____ Date_____

Dry Eye Questionnaire

- Do you have discomfort or "feel" your eyes? Yes / NO
- Do you have vision fluctuations or do you feel that you have to blink to see better? Yes / NO
- Do you have issues seeing out of your glasses or contact lenses? Yes/ NO
- Do you use eye drops for lubrication? Yes/ NO If yes, how often_____ What brand?_____

Please fill out this Standardized Patient Evaluation of Eye Dryness (SPEED). Please fill this out completely and don't leave anything blank.

1. Report the type of **SYMPTOMS** you experience and when they occur:

	At this visit		Within past 72 hours		Within the past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or watering						
Eye Fatigue						

2. Report the **FREQUENCY** of your symptoms using the rating listed 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				

3. Report the **SEVERITY** of your symptoms using the rating listed 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**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

For office use:

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Please list all **products and treatments** you have tried in the past. Circle what you are currently using and indicate the frequency.

Tell me about your day:

How do your eyes feel when the alarm goes off in the **morning**? Circle all that apply

Fine Sticky/watery Uncomfortable/dry Extremely dry Other_____

How do they feel **midday**? Circle all that apply

Fine Sticky/watery Uncomfortable/dry Extremely dry Other_____

How do they feel at **night**? Circle all that apply

Fine Sticky/watery Uncomfortable/dry Extremely dry Other_____

How do you spend your day? Circle all that apply

Outside most of the day Driving Indoors most of the day Computer/Tablet/phone Other_____

What's your occupation? How many hours a day do spend on a computer/tablet/phone?

Do you frequently work over 40 hours/ week? YES/ NO If yes, how many hours a week do you typically work?_____

Do you wear contact lenses? YES/ NO If yes, do you experience contact lens discomfort? YES/ NO

Please circle any dry eye symptoms you have:

Dryness or Grittiness	Burning	Stringy mucous
Fluctuating or blurry vision	Light sensitivity	Scratching feeling
Must blink to see better	Watering or tearing	None
Redness	Tired eyes	Other:
Itchiness	Foreign body sensation	

Health history

Certain medication and medical conditions can affect your tear film.

What medical conditions do you have? Circle all that apply

Arthritis	Eczema	Rheumatoid arthritis
Autoimmune disease	Fibromyalgia	Rosacea
Allergies/Hypersensitivity	Herpes	Sarcoidosis
Bells Palsy	Hypertension	Sjogrens
Chemo/ Radiation	Hyperthyroid	Sleep apnea/ uses CPAP
Diabetes	Hypotheyroid	NONE
Dermatitis	Lupus	

Do you take any of the following medication? Circle all that apply

Diuretic	Botox injections	Fish oil
Antihistamine	Antidepressant / Antianxiety	Flaxseed oil
Decongestant	Hormone replacement	
Accutane (or have taken in past)	Oral contraceptives	

Do you experience unexplained joint pain? YES/ NO **Do you have dry mouth?** YES/ NO

Nutrition and Lifestyle

The next section is going to ask you a lot of very specific questions. The reason for these questions is to understand you a little better so we can make our treatment plan individualized for you to achieve the best outcome. There are 5 pillars of health (nutrition, exercise, meditation, sleep, and hydration). We need to understand how strong your pillars are and possibly work to make them stronger.

How much water do you consume a day?_____

What type of water do you drink? Circle all that apply Bottle City Well Distilled RO

Over ->

Fill in the number that applies: 0 or leave blank = do not consume or use 1= Consume or use 2-3 times a month

2= consume or use weekly 3= consume or use daily

___ Alcohol
___ Artificial sweeteners
___ Candy or sweets
___ Chewing tobacco
___ Cigarettes
___ cigars/pipes
___ Coffee
___ Fast food
___ Fried food
___ Luncheon meats/hotdogs
___ Margarine
___ Milk products
___ Non herbal tea
___ Refined flour/baked goods
___ Refined sugar

Fill in the number that applies: 0 or leave blank = do not consume or use 1= Consume less than daily

2= consume daily 3= consume several times a day

___ Fruit
___ Vegetables
___ Vitamins/minerals
___ Fish (what type and is it fresh caught or farm raised?)
___ Probiotics/ fermented foods

Do you follow a specific diet? YES/ NO If yes, please specify_____

If needed, are you willing to modify your diet to reduce inflammation and improve health? YES/ NO / Maybe

Do you tend to buy organic produce/meat/eggs? YES/ NO / When I can

Do you tend to avoid GMO's? YES / NO / Unsure

Packaged food usually contain seed oils (corn, canoloa, cottonseed, soy, sunflower, grapeseed) which are very proinflammatory. Will you be willing to look out for these when you purchase food? YES /NO

Where do you get your food? Circle all that apply: Supermarket Farmers Market Local meat/ buy a cow Grow my own Online

What supplements do you take (include brand if you know it)?

How many times a week do you meditate? _____

How many times a week do you exercise or walk for at least 20 minutes? _____

Do you have difficulty falling asleep? YES/ NO **Do you stay asleep all night?** YES/ NO

How many hours a night do you typically sleep? _____

Treatment Expectations :

There is no one silver bullet that will treat your whole condition. You can't have everything fast, natural, easy and cheap. There are many roads we can go down, and we are partners in this. We must make choices on what is important to you and keep these choices in mind when establishing expectations for relief.

Examples:

1. We can get faster relief using natural methods and with less tasks in your at-home treatment regimen, but it may not be cheap because insurance coverage of the more effective dry eye solutions is poor.
2. We can implement only what insurance covers, but it won't be natural, fast, or easy. It will be a long term steroid, antibiotic, or immunosuppressant pharmaceuticals and will require a lot of at home care throughout the day.

What is most important to you? Please circle one answer per column

Choose one:	Choose one:	Choose one:	Choose one:
Fast	Natural	Easy (less work at home)	Transforming relief
Economical	Economical	Economical	Ignore you lifestyle contributions