KOBY KARP Doctors Eye Institute

DRY EYE QUESTIONNAIRE

To help your doctor determine if you have Dry Eye Disease, answer the 12 questions below. Then fill in the boxes A,B,C,D and E according to the instructions beside each.

Have you experienced any of the following *DURING THE LAST WEEK*?

	Physical Symptoms	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
1	Eyes that are sensitive to light	4	3	2	1	0	N/A
2	Eyes that feel gritty	4	3	2	1	0	N/A
3	Painful or sore eyes	4	3	2	1	0	N/A
4	Blurred vision	4	3	2	1	0	N/A
5	Poor vision	4	3	2	1	0	N/A

Subtotal score for answers 1 to 5 [A]

Have problems with your eyes limited you in performing any of the following *NG THE LAST WEEK*?

	Daily Activities	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
6	Reading	4	3	2	1	0	N/A
7	Driving at night	4	3	2	1	0	N/A
8	Working with a computer or ATM	4	3	2	1	0	N/A
9	Watching TV	4	3	2	1	0	N/A

Subtotal score for answers 6 to 9 [B]

Have your eyes felt uncomfortable in any of the following situations *DURING THE LAST WEEK*?

	Environmental Factors	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
10	Windy conditions	4	3	2	1	0	N/A
11	Places with low humidity (very dry)	4	3	2	1	0	N/A
12	Areas that are air conditioned	4	3	2	1	0	N/A

Subtotal score for answers 10 to 12 [C]

ADD SUBTOTALS A, B AND C TO OBTAIN D [D] TOTAL NUMBER OF QUESTIONS ANSWERED [E]

NAME____ Date ____________

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Please print out, fill in and bring with you to our office.