

# WOODBIDGE OPTOMETRY

## DRY EYE SURVEY

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

Do your eyes ever feel or do you experience:

Gritty, sandy, or burning sensation? Never Slight Moderate Severe

Pain or soreness? Never Slight Moderate Severe

Fluctuating vision? Never Slight Moderate Severe

Occasional Tearing? Never Slight Moderate Severe

Blurred vision while reading? Never Slight Moderate Severe

Discomfort in windy conditions? Never Slight Moderate Severe

Discomfort in air-conditioned areas? Never Slight Moderate Severe

Itching? Never Slight Moderate Severe

Eye Redness? Never Slight Moderate Severe

What medications do you take? \_\_\_\_\_.

How much time do you spend on the computer? \_\_\_\_\_.

Please return this completed form to your doctor at Woodbridge Optometry during your next appointment.