EYE QUESTIONNAIRE

FAGADAU & HAWK
NORTH TEXAS EYE RESOURCE
Eye Physicians & Surgeons

NAME:_______________________________ DATE:______________________

Please circle *yes* or *no* if you have had any of the following symptoms in the (6) months?

Eyes feel dry	yes	no
Eyes feel teary or wet	yes	no
Red or "bloodshot"	yes	no
Burning	yes	no
Sandy or gritty	yes	no
Feels like something in eyes	yes	no
Tired or fatigued	yes	no
Feels strained	yes	no
Feels like pressure	yes	no
Need to blink often to focus	yes	no
Feels like film over eyes	yes	no
Itchy	yes	no
Double vision at times	yes	no
Eyes ache	yes	no
See shadowing on letters	yes	no
Headaches	yes	no
Trouble with reading	yes	no
Vision blurring at times	yes	no
Discharge or matting	yes	no
Sticky sensation	yes	no

Are any of the symptoms worse in the morning? yes no

Do the symptoms get worse as the day goes on? yes no

How long have you lived in Dallas area?

Do you have any of the following?

Blepharoplasty	yes	no
Chemotherapy	yes	no
Facial Surgery	yes	no
Lasik	yes	no
PRK	yes	no
Hysterectomy	yes	no
Botox	yes	no

If yes to Botox, when was last injection?

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Do you take diuretics (water pills) or use a diet pill?	yes	no
Do you see a rheumatologist for any reason such as: Rheumatoid arthritis, Lupus, Sjogren's syndrome, Scleroderma?	yes	no
Do you have Bell's palsy?	yes	no
Do you use a CPAP at night? (breathing machine)	yes	no
Do you sleep under a moving fan or floor fan?	yes	no
Do you have Dry mouth?	yes	no
Do you have trigeminal neuralgia (fifth nerve problem)?	yes	no
Do you use supplemental oxygen?	yes	no
Do you have a parotid tumor?	yes	no
Do you have a skin disorder?	yes	no
Do you have a thyroid disease?	yes	no

FOR CONTACT LENS WEARERS ONLY:

Are they colored?	yes	no
Do they stick to your eyes?	yes	no
Do they pop out?	yes	no
Do they get protein deposits?	yes	no
Do you sleep in them?	yes	no
Do you have to order them more frequently than expected?	yes	no
Do you have days when you cannot put them in or have to remove them earlier than you would like to?	yes	no