Dr. Kreda's Dry Eye Evaluation Questionnaire

First Name _____ Last Name _____

Phone (___) ___-____ Email _____

How Often do you have ...?	Never	Sometimes	Frequently	Always	Score
Redness	○	○	○	○	
Sandy or Gritty Sensation	○	○	○	○	
Itching	○	○	○	○	
Excess Watering	○	○	○	○	
Burning	○	○	○	○	
Excess Mucous	○	○	○	○	
Blurred Vision	○	○	○	○	
Are your eyes sensitive to ...?	Never	Sometimes	Frequently	Always	Score
Smoke	○	○	○	○	
Light	○	○	○	○	
Air Pollution	○	○	○	○	
Wind	○	○	○	○	
Heaters	○	○	○	○	
Air Conditioning	○	○	○	○	
Contact Lenses	○	○	○	○	
How often do you use ...?	Never	Sometimes	Frequently	Always	Score
Anti-Depressants	○	○	○	○	
Redness Reducing Eye Drops	○	○	○	○	
Decongestants	○	○	○	○	
Antihistamines	○	○	○	○	
Blood Pressure Medication	○	○	○	○	
Artificial Tear Drops	○	○	○	○	
Hormones	○	○	○	○	
Oral Contraceptives	○	○	○	○	
Diuretics	○	○	○	○	
Ulcer Medication	○	○	○	○	
Tranquilizers	○	○	○	○	
Beta Blockers	○	○	○	○	
Incontinence Therapies	○	○	○	○	
Average daily computer time	0 Hrs	1-2 Hrs	2-4 Hrs	Over 4 Hrs	Score
Hours	○	○	○	○	

Have you ever been diagnosed with…?	Yes	No	Score
Thyroid Abnormalities	○	○	
Rheumatoid Arthritis	○	○	
Asthma	○	○	
Diabetes	○	○	
Glaucoma	○	○	
Are you…?	Yes	No	Score
Over 45	○	○	
Post-menopausal	○	○	
Considering refractive surgery	○	○	
Do you…?	Yes	No	Score
Experience Contact Lens discomfort	○	○	
Get eyestrain	○	○	
Blink your eyes excessively	○	○	
As an Adult…?	Yes	No	Score
Have you had blemishes on your face?	○	○	

Total Score: _____

To Score: Column 1=0 Column 2=3 Column 3=4 Column 4=5

Yes=3 No=0

If you scored 30 or higher you may have dry eyes. Please call our office for an evaluation

(954) 749-0000