Dry Eye / Allergy Questionnaire

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VANCE THOMPSON VISION

Patient Name: _____ Date: _____

To accurately obtain the best measurements in our testing and/or to maximize your surgical outcomes, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

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

Symptoms	Within past 3 months	
	Yes	No
Dryness, grittiness or scratchiness		
Soreness or irritation		
Burning or watering		
Itchy or swollen eyes		
Nasal symptoms		
Eye fatigue		
Redness		
Vision fluctuation		

2. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	0	1	2	3	4
Dryness, grittiness or scratchiness					
Soreness or irritation					
Burning or watering					
Itchy or swollen eyes					
Nasal symptoms					
Eye fatigue					
Redness					
Vision fluctuation					

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

3. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0	1	2	3
Dryness, grittiness or scratchiness				
Soreness or irritation				
Burning or watering				
Itchy or swollen eyes				
Nasal symptoms				
Eye fatigue				
Redness				
Vision fluctuation				

0 = Never
1 = Sometimes
2 = Often
3 = Constant

4. Do you use eye drops for lubrication?

☐ **Yes** ☐ **No** **If yes, how often?** _____

5. Do your symptoms affect the quality of your life?

☐ **Yes** ☐ **No** **If yes, how often?** _____