DRY EYE EXTENDED HISTORY

Full Name _____

Date Of Birth _____ **Age:** _____

In preparation for your ocular surface disease consultation, please provide the following medical and lifestyle information. Your answers will help the doctor better understand the cause of your condition and guide your treatment.

if you need more space than provided please continue on the back page

SYMPTOMS

1. Please circle the words that relates to your symptoms:

Burning	Itching	Mattering	Irritated	Redness
Blurry	Sore	Watering	Fatigue /Tired	Scratchy
Excessive blinking		Dry	Gritty/Sandy	Ache

2. In your own words, please describe your symptom onset and how your eyes feel most days:
(example: When did you first notice your symptoms? One eye? Both eyes? Constant or Intermittent? Are you more symptomatic at certain times for the day (e.g. late afternoon, when you wake up)?

TREATMENTS

What drops, gels, ointments or other treatments do you currently use.
Please list how often you use the treatments and brand name if known.
Example: Systane Balance, twice a day

Which of the above provides relief, and to what degree?
Example: The Systane Balance helps about 50%

If you can recall, it would be helpful to know what drops, gels, ointments or procedures (e.g. Restasis, plugs, Lipiflow, IPL) that you have tried previously:
Example: I've tried some type of fish oil and Restasis

VITAMINS & SUPPLEMENTS

Please list any vitamins or nutritional supplements you take
(VERY IMPORTANT - PLEASE BRING THEM WITH YOU TO YOUR APPOINTMENT)

LIFESTYLE

Many factors impact our tear production, from what we eat and drink to our jobs and hobbies, all can play a role in our symptoms. Small lifestyle modifications often contribute to relief.

- **How many ounces of water do you drink per day?** _____
- **How many caffeinated drinks per day(coffee tea)?** _____
- **Do you drink soda or diet soda?** _____
- **Do you (or a bed partner) use a c-pap device?** _____
- **Do you use ceiling fan(s)?** _____
- **Do you frequently drive long distances for work or pleasure?** _____
- **Do you travel by airplane? If so, how many trips per year?** _____
- **Does your workplace create any environmental challenges (e.g. fans, no air conditioning, etc)** _____

Occupation: _____

Hobbies: _____

DIGITAL DEVICE USE

1. How many hours per day do you use digital devices
(phone, tablet, desktop): _____

2. Do you wear blue-light protective lenses when using digital devices?
Yes No Don't know

SUPPLEMENTAL MEDICAL HISTORY

List any facial cosmetic or ocular procedures you've had in the past:
(*example: cosmetic surgery, eyelid surgery, punctal plugs, etc.*)

History of acne treatment: *(example: Accutaine)* **Yes** **No** **Unknown**

HORMONE RELATED TEAR PRODUCTION

Our hormones play important roles in our body, including tear production. Please list any hormone-related issues past or present (e.g. irregular periods, menopause, use of synthetic or bioidentical hormones, low testosterone, menopause, etc.)

CONTACT LEN HISTORY

1. **Do you currently wear contact lenses?** _____
2. **How many hours/day?**_____
3. **How many days/week?** _____
4. **How many hours can you wear your contact lenses prior to declining comfort or the need to use eye drops?**_____
5. **What care system do you use (if not using daily replacement lenses)?**_____
6. **How often do you insert a fresh lens?** _____
7. **Have you tried contact lenses but unable to continue due to comfort?** _____

EYE SURGICAL HISTORY

For refractive surgery patients:

☐ **laser vision correction** ☐ **Radial keratotomy** ☐ **Cataract surgery**

Other _____

AESTHETICS

1. **Have you had permanent eyeliner applied/tattooed? YES NO**
2. **Have you used lash extensions (or considering in the future)? YES NO**
3. **What do you use to remove your eye makeup?**

4. **What skin care products do you use (e.g. serum, moisturizer)**

5. **Check the box next to the products listed below if you would be interested in learning more about our recommendations:**
   - ☐ **skin care, especially around the eyes**
   - ☐ **eye-safe cosmetics**
   - ☐ **lash/brow enhancing**

DOCTOR USE ONLY

SYSTEMIC CONDITIONS THAT MAY IMPACT OCULAR SURFACE:

SYSTEMIC or OCUAR MEDICATIONS THAT MAY IMPACT OCULAR SURFACE:

VITAMIN D LEVEL (IF KNOWN OR REQUESTED):

SPEED Score (if know):

OTHER INFORMATION: