Questionnaire for Dry Eye Disease/Ocular Surface Disease Evaluation

Date: ___/___/___

Name:_____ Date of Birth: ___/___/___

Dry Eye Disease is one of the most frequent reasons for visits to eye doctors. Therefore, we ask that you take a few moments and thoughtfully complete the questions below:

Do you have fluctuating vision problems that get better with blinking (circle one)?

Never Sometimes Frequently A lot/always

***FREQUENCY*: How <u>often</u> are you experiencing the following symptoms?**

Symptoms	Never 0	Sometimes 1	Often 2	Constant 3
Dry/Gritty				
Scratchy/Sore				
Irritation				
Burning/Watering				

***SEVERITY*: How <u>bothersom</u>e are the following symptoms that you're experiencing:**

Symptoms	**Never-0** No problems	**Tolerable-1** Not perfect, not uncomfortable	**Uncomfortable-2** Irritating. Does not interfere with my day	**Bothersome-3** Irritating. Affects my day	**Intolerable-4** Unable to perform my daily tasks
Dry/Gritty					
Scratchy/Sore					
Irritation					
Burning/Watering					

Mark an X if you had these symptoms:

[ ]Today [ ]in the past 72 hours [ ]in past 3 months

Do you use eye Drops? □Yes □No

Have you used them in the past 2 hours? □Yes □No

For office use only:

SPEEDscore:

tOSM:____/____

Name of eye drops/ointments and usage: _____

_____

ICON EYECARE
GRAND JUNCTION

Pre Surgical

Cataract Patient Questionnaire

Patient Name: _____

Date: _____

Chart Number: _____

Eye Being Evaluated: □Right Eye □Left Eye

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?

	YES	NO
1) Reading small print, such as labels on medicine bottles, telephone books or food labels?	□	□
2) Reading a newspaper or book?	□	□
3) Reading a large-print book or large-print newspaper?	□	□
4) Recognizing people when they are close to you?	□	□
5) Seeing steps, stairs or curbs?	□	□
6) Reading traffic signs, street signs or store signs?	□	□
7) Doing fine handwork like sewing, knitting, crocheting or carpentry?	□	□
8) Writing checks or filling out forms?	□	□
9) Playing games such as bingo, dominoes or card games?	□	□
10) Taking part in sports like bowling, handball, tennis or golf?	□	□
11) Cooking?	□	□
12) Watching television?	□	□

SYMPTOMS

Have you been bothered by the following?

	YES	**NO**
1) Poor night vision?	□	□
2) Seeing rings or halos around light?	□	□
3) Glare caused by headlights or bright sunlight?	□	□

Patient Name: _____

Eye Being Evaluated:
□ Right Eye □Left Eye

SYMPTOMS

Have you been bothered by the following

	YES	NO
4) Hazy and/or blurry vision?	□	□
5) Seeing well in poor or dim light?	□	□
6) Poor color vision?	□	□
7) Double vision from one eye?	□	□

DRIVING

1) Have you ever driven a car? □ YES (Continue to Question 2) □ No (Stop Here)

2) Do you currently drive a car? □ YES (Continue to Question 2) □ No (Stop Here)

3) How much difficulty do you have driving during the day because of your vision?

□ No difficulty □ Moderate amount of difficulty
□ Little Difficulty □ Great deal of difficulty

4) How much difficulty do you have driving during at night because of your vision?
□ No difficulty □ Moderate amount of difficulty
□ Little Difficulty □ Great deal of difficulty

5) When did you stop driving?
□ Less than 6 months ago □ 6-12 months ago □ More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision anymore and of the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

□ YES □ NO

Patient Signature: _____ Date: _____

Print Name: _____