Patient Name: _______________________________ Date: ______________

**DRY EYE SURVEY**

Do your eyes ever feel or do you experience:

- **Gritty or sandy sensation?**
  - Never
  - Slight
  - Moderate
  - Severe

- **Pain or soreness?**
  - Never
  - Slight
  - Moderate
  - Severe

- **Fluctuating vision?**
  - Never
  - Slight
  - Moderate
  - Severe

- **Occasional Tearing?**
  - Never
  - Slight
  - Moderate
  - Severe

- **Blurred vision while reading?**
  - Never
  - Slight
  - Moderate
  - Severe

- **Discomfort in windy conditions?**
  - Never
  - Slight
  - Moderate
  - Severe

- **Discomfort in air conditioned areas?**
  - Never
  - Slight
  - Moderate
  - Severe

---

**ALLERGY SURVEY**

Do you EVER suffer from red eyes, itchy eyes, watery eyes, or swollen eye lids?

- **Yes**
- **No**

Do you EVER use an over-the-counter or prescribed eye drops (i.e. VISINE A, VISINE AC, OCPON A, etc.) to treat red eyes, itchy eyes, watery eyes, or swollen eye lids?

- **Yes**
- **No**

Do you take any prescribed or over the counter medications like CLARITIN, ALLEGRA, or ZYRTEC for your allergies?

- **Yes**
- **No**