VALERIE L. JONES, O.D

MEMBER Vision Source™ NETWORK

Patient Name:____ Date:___________________

Dry Eye Questionnaire

Please complete the questionnaire below.
Circle the score that most closely describes your situation.

THE **FREQUENCY** OF YOUR SYMPTONS
0 = NEVER 1 = SOMETIMES 2 = OFTEN 3 = CONSTANT

SYMPTOMS				
Dryness, Grittiness or Scratchiness	0	1	2	3
Soreness or Irritation	0	1	2	3
Burning or Watering	0	1	2	3
Eye Fatigue	0	1	2	3

THE **SEVERITY** OF YOUR SYMPTOMS
0 = NO PROBLEMS 1 = TOLERABLE 2 = UNCOMFORTABLE 3 = BOTHERSOME 4 = INTOLERABLE

SYMPTOMS					
Dryness, Grittiness or Scratchiness	0	1	2	3	4
Soreness or Irritation	0	1	2	3	4
Burning or Watering	0	1	2	3	4
Eye Fatigue	0	1	2	3	4

EARLY SYMPTOMS OF Age Related Macular Degeneration

Before any structural changes can be seen in the back of your eye, you may experience the following early symptoms.

Check all that apply:

[ ] Difficulty seeing in the dark [ ] Difficulty navigating at night [ ] Difficulty reading in dim light

[ ] Other night vision problems (please specify) ____

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