Name_____ Age_____ Gender_____ OSDI Score_____

Dry Eye History and Intake Form

Do you have any of the following medical conditions?			**Do you take any of the following medications?**		
● Diabetes Mellitus	___Yes	___No	● Antihistamines (Claritin, Allegra, etc)	___Yes	___No
● Rheumatoid Arthritis	___Yes	___No	● Antidepressants	___Yes	___No
● Sjogren's Syndrome	___Yes	___No	● Antispasmodics	___Yes	___No
● Stevens-Johnson Syndrome	___Yes	___No	● Antihypertensives (Diuretics, Beta Blockers)	___Yes	___No
● Rosacea	___Yes	___No	● Oral Corticosteroids	___Yes	___No
● Systemic Lupus Erythematosus	___Yes	___No	● Oral Contraceptives	___Yes	___No
● Viral Infection (HIV, Hepatitis C, Epstein Barr)	___Yes	___No	● Hormone Replacement Therapy	___Yes	___No
● Parkinson's Disease	___Yes	___No	● Accutane	___Yes	___No
● Bell's Palsy	___Yes	___No	● Nutritional Supplements (Omega 3's, flax seed oil)	___Yes	___No
● Lymphoma	___Yes	___No			
● Sarcoidosis	___Yes	___No			
Have you ever undergone any of the following medical procedures?			**Do you use any of the following topical (eye drop) medications?**		
● Radiation Therapy	___Yes	___No	● Decongestants ("Get the Red Out" - Visine, Clear Eyes, etc)	___Yes	___No
● Bone Marrow/Stem Cell Transplantation	___Yes	___No	● Topical Antihistamines ("Get the Itch Out" - Zaditor, Alaway)	___Yes	___No
● Eyelid Surgery	___Yes	___No	● Artificial Tears	___Yes	___No
● Punctal Occlusion	___Yes	___No	● Gel Tears	___Yes	___No
● Refractive Surgery (LASIK, PRK)	___Yes	___No	● Restasis	___Yes	___No
Do you partake in any of the following?			**Do you have any of the following symptoms?**		
● Smoke	___Yes	___No	● Foreign body sensation	___Yes	___No
● Wear Contact lenses	___Yes	___No	● Eye soreness	___Yes	___No
● Prolonged Reading	___Yes	___No	● Eye dryness	___Yes	___No
● Prolonged Computer work	___Yes	___No	● Grittiness	___Yes	___No
			● Itching	___Yes	___No
			● Stinging	___Yes	___No
			● Intense Burning	___Yes	___No
			● Watery eyes	___Yes	___No
			● Red Eyes	___Yes	___No
			● Blurry Vision	___Yes	___No
			● Time of day influence	___Yes	___No