

Ocular Surface Evaluation Questionnaire

Metro Eye's Dry Eye and Ocular Surface Disease Clinic is dedicated to offering its patients excellent care with the use of up-to-date diagnostic and treatment options. Dry eye disease is multifactorial, meaning there are many different causes and conditions that can affect treatment decisions and outcomes. We ask that you complete this brief questionnaire in order to aid the doctor in identifying factors that could be contributing to your disease and symptoms.

Please complete the following and mail back the completed form using the pre-stamped envelope *one week prior to your appointment* so that the doctor has time to review.
Thank you.

Date: _____

Patient Name: _____

Date of Birth: _____

Reason for Visit (please include treatment goals or complaints if pertinent):

Referred By: _____

Patient Medical History

- Hypertension
- Diabetes
- Skin disease, i.e. rosacea, eczema, psoriasis
- Thyroid disease
- Hormone replacement therapy
- Allergies

Please indicate type: dust, animals, seasonal, other _____

- Dry mouth or trouble swallowing
- Achy joints or chronic pain
- GI upset or heartburn
- Chronic fatigue
- Cancer _____
- Autoimmune disease

Please indicate type: RA, Sjorgren's, Crohn's disease, other _____

- Alcoholism
- Insomnia

Smoker

- Current Never smoker Previous smoker: from _____ to _____

Family History

- Skin disease, i.e. rosacea, eczema, psoriasis
- Autoimmune disease, i.e. rheumatoid arthritis, Sjorgren's
- Cancer _____

Current Medications:

- OTC pain medication
- Allergy meds/decongestants
- Oral contraceptives
- Antacids
- Hormone Replacement Therapy
- Acne medication (currently or in the past) _____

Accutane? Y N

Other Medications:

Name: _____ Dose: _____

Current Supplements:

Omega-3 Fish Oil _____ mg DHA _____ mg EPA

Other

Name: _____ Dose: _____

Patient Ocular History

- Glaucoma
- Eye injury
- Blepharitis or other eyelid disorder
- Previous diagnosis of dry eye or ocular surface disease

If yes, past treatment _____

Eye Surgery

- No
- Yes: LASIK PRK Cataract Lid surgery
- Other _____

Contact Lens History

- Never, but interested Never, and **not** interested
- Former:
 - Discontinued due to intolerance
 - Discontinued due to other reason _____
- Current with no problems
- Current with limitations (Please explain): _____

Years wearing contact lenses _____

Type of lens:

Soft: Daily Disposable 2 Week Disposable Monthly Disposable

Other _____

Hard/Gas-Permeable

Do you sleep in your contact lenses?

No Yes Every night _____ nights per week

Contact lens solution:

Opti-free Renu Clear Care Boston Other: _____

Do you use contact lens re-wetting drops or artificial tears?

No Yes How many drops a day? 1-2 3-4 >4
Name of drops: _____

Current Glasses

How old is your current glasses prescription? _____

When was your last refraction (glasses prescription update)? _____

How often do you wear your glasses (or for what purpose/tasks)? _____

Any pertinent problems/concerns regarding glasses wear? _____

Current Eye Treatment:

Current eye drops/ointments (prescription and/or over the counter):

Name: _____ Dose: _____

Bruder mask or alternative heat therapy _____

Eyelid hygiene (wipes or sprays) _____

Other _____

SPEED Questionnaire

I. Report the type of symptoms you experience and when they occur by placing an 'X' in the appropriate box:

Symptoms	Currently		Within Past 72 Hours		Within Past 3 Months	
	Yes	No	Yes	No	Yes	No
Dryness, Grittiness, or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

II. Report the frequency of the above-checked symptoms as:

0 = Never, 1 = Sometimes, 2 = Often, or 3 = Constant

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

III. Report the severity of your symptoms using the rating list below:

0 = No problems

1 = Tolerable: not perfect, but not uncomfortable

2 = Uncomfortable: irritating, but does not interfere with my day

3 = Bothersome: irritating and interferes with my day

4 = Intolerable: unable to perform my daily tasks

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

Internal Use Only:

Total SPEED Score: _____ /28 | Mild 1-5 | Severe 11-28 | Moderate 6-10

Convergence Insufficiency Symptom Survey

Please select the answer that best describes your average day by indicating with an 'X' in the appropriate box

	Never	Infrequently	Sometimes	Often	Always
1. Do your eyes feel tired when reading or doing close work?					
2. Do your eyes feel uncomfortable when reading or doing close work?					
3. Do you have headaches when reading or doing close work?					
4. Do you feel sleepy when reading or doing close work?					
5. Do you lose concentration when reading or doing close work?					
6. Do you have trouble remembering what you have read?					
7. Do you have double vision when reading or doing close work?					
8. Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
9. Do you feel like you read slowly?					
10. Do your eyes ever hurt when reading or doing close work?					
11. Do your eyes ever feel sore when reading or doing close work?					
12. Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13. Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14. Do you lose your place while reading or doing close work?					
15. Do you have to re-read the same line of words when reading?					

Lifestyle Questionnaire

Please indicate your answer by marking the with an 'X.'

1. How many hours do you spend in front of a computer, phone, or ipad/device?

<1 hour 1-3 hours 4-6 hours 7-9 hours >9 hours

2. Air quality at work:

Seems normal Dry; I use a humidifier Dry; no humidifier

3. Air quality at home:

Seems normal Dry; I use a humidifier Dry; no humidifier

4. Do you sleep with a fan on?

Yes No

5. How many hours of sleep do you get per night?

< 4 hours 4-5 hours 6 or more hours

6. Do you have pets?

Yes No

7. How many hours do you spend driving?

< 1 hour 1-2 hours >2 hours

8. How much water do you drink a day?

< 2 glasses 3-5 glasses 6-8 glasses >8 glasses

9. Do you wear eye make-up?

No Yes

Do you remove it before bed? Yes No Sometimes

10. Do you use any make-up, lotions/creams, or cosmetics with the following ingredients?

Salicylic acid Benzoyl Peroxide

Sodium lauryl/laureth sulfate Parabens

Retinoic acid, Triretinoin, Retin-A, Retinol

Formaldehyde and Formaldehyde-Releasing Preservatives:

Formaldehyde, Quaternium-15, DMDM hydantoin, Imidazolidinyl urea, Diazolidinyl urea, Polyoxymethylene urea, Sodium hydroxymethylglycinate, 2-bromo-2-nitropropane-1, 3-diol (bromopol), and Glyoxal

11. Have you had any cosmetic procedures?

- Blepharoplasty i.e. lid surgery
- Botox
- Intense Pulsed Light Therapy (IPL)
- Lash Extensions
- Tattooed Make-up
- Other: _____

12. Do you use Eyelash Growth Serum (i.e. Latisse, Rodan and Fields, etc.)?

- Yes
- No

13. Do you use a CPAP machine?

- Yes
- No

14. Please use the following space to remark on any other concerns or factors that you believe may be contributing to your symptoms.

Thank you for completing the Ocular Surface Evaluation Questionnaire.

Please feel free to contact the office with any additional questions or concerns.

Phone: 414-727-5888

Fax: 414-727-5889

Email: osdclinic@metroeye.biz

Please remember to return this completed form prior to your next appointment.

We look forward to seeing you.

Ocular Surface Disease Diagnostic Testing

TEAR OSMOLARITY

Tear Osmolarity is a measurement of how salty your tears are. High tear osmolarity is associated with damage to the surface of the eye. Tracking tear osmolarity can be an indicator of how therapy is working and risk for ocular surface damage.

In order for the test to be accurate, please **do not use any eye drops within two hours of your appointment**. A small sample of tears will be collected from each eye using a handheld device. The test takes less than a minute to complete on each eye.

Depending on your results, tear osmolarity may be assessed as frequently as every visit with the doctor in order to track changes and/or trends in the quality of your tears.

INFLAMMADRY

Inflammadry is a diagnostic test that is used to detect specific inflammatory mediators on the surface of the eye. Inflammation is associated with chronic irritation and can lead to permanent damage on the eye surface.

Please **do not use any eye drops within two hours of your appointment**, as this may skew results. This test is typically performed on only one eye, with a small sample of tears being taken using a handheld device. The test takes less than one minute to complete.

Similar to Tear Osmolarity, depending on your test results, Inflammadry may be assessed at each visit with the doctor in order to analyze the status of the ocular surface and gauge treatment outcomes.

LIPISCAN

Lipiscan is a device the doctor uses in order to obtain an infrared image of the meibomian glands. By directly viewing the glands in the eyelids, the doctor is able to assess if there are changes in the structure of the gland that would indicate improper gland function. If the gland is not functioning correctly, structural damage can occur and eventually lead to gland loss and chronic dry eye.

The scan is not invasive and usually takes only a few minutes to complete. The doctor will review your Lipiscan image with you at the time of your appointment. Typically, the scan is performed once a year.

Inflammadry and **Tear Osmolarity** are billable to your medical insurance.

LipiScan is not billable to insurance; it is an out of pocket charge of \$49.