DRY EYE PATIENT IMPACT QUESTIONNAIRE

Name: ____Date:________

The following questions refer to Eye Symptoms you may have or have ever had. Please answer each question by writing in a number or marking the number which best describes your situation.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking below:

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

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

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

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

Please mark with an "X":

DO YOU HAVE:	Yes	No
Dry Mouth?		

Joint Pain or Arthritis		
Worsening vision with computer, driving or television		