

Dry Eye Disease is a common reason that patients visit eye doctors, and it can have an impact on surgical outcomes. Please take a moment to thoughtfully complete the questionnaire.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Report the **FREQUENCY** of your symptoms using the rating list below:

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

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

2. Report the **SEVERITY** of your symptoms using the rating list below:

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

0 = No problems  
 1 = Tolerable – not perfect but not uncomfortable  
 2 = Uncomfortable – irritating but doesn't interfere with my day  
 3 = Bothersome – irritating and interferes with my day  
 4 = Intolerable – unable to perform my daily tasks

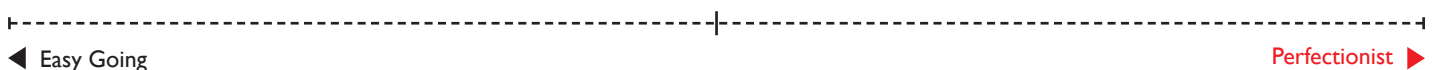
(adapted from the SPEED questionnaire with permission from J&J)

Do you use eye drops for lubrication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many times per day? _____	
Do you have fluctuating vision? (choose one)	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently	<input type="checkbox"/> Always
If yes, does the fluctuating vision improve with blinking and/or lubricating drops?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Have you been told you have <b>blepharitis</b> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, is it due to mites (i.e., Demodex)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any autoimmune diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, which one(s)? _____	
Have you had any of these symptoms recently?	<input type="checkbox"/> Eyelid redness	<input type="checkbox"/> Crusting around lashes	<input type="checkbox"/> Lid irritation	<input type="checkbox"/> Styte/Chalazion
Have you ever had vision correcting surgery (e.g., LASIK, PRK, SMILE)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do your eyes and/or eyelids/lashes itch? (choose one)	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently	<input type="checkbox"/> Always
If yes, do you have known environmental allergies or allergic conjunctivitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are your ocular symptoms symmetric between both eyes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, which eye is the most symptomatic? <input type="checkbox"/> Right <input type="checkbox"/> Left	

Do you mind wearing glasses and/or contact lenses for improving your vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you successfully used monovision? (e.g., one eye for distance and the other for near vision)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			If yes, which eye was the distance vision eye?	<input type="checkbox"/> Right	<input type="checkbox"/> Left
If yes, would you be willing to pay out-of-pocket costs to reduce or eliminate your dependence on them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you successfully used multifocal contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please place an "X" on the following scale to describe your personality as best you can:



For office use only: Total Score (Frequency + Severity) = \_\_\_\_\_ /28 Number of RED boxes checked= \_\_\_\_\_ /16

Compare all available preoperative refractive measurements (keratometry, topography, optical biometry, aberrometry, etc.).		
What is the greatest difference in average K between any two devices?	<input type="checkbox"/> ≤0.5 D	<input type="checkbox"/> >0.5 D to 1.0 D <input type="checkbox"/> >1.0 D
What is the greatest difference in astigmatism axis between any two devices?	<input type="checkbox"/> ≤0.5°	<input type="checkbox"/> >5° to 10° <input type="checkbox"/> >10°