Visual Answers Dry Eye Survey After 90 Day Treatment Plan

Visual Answers
OPTOMETRISTS

Section 1: ***During the past week how often did you experience these dry eye problems?***

	NEVER	SOMETIMES	FREQUENTLY	ALWAYS
REDNESS	0	2	3	4
SANDY/ GRITTY FEELING	0	2	3	4
ITCHING	0	2	3	4
EXCESS WATERING	0	2	3	4
BURNING	0	2	3	4
MUCOUS DISCHARGE	0	2	3	4
BLURRY VISION (CORRECTED BY BLINKING)	0	2	3	4
Total Score of Section 1				

Section 2: ***During the past week were your eyes sensitive to these conditions?***

	NEVER	SOMETIMES	FREQUENTLY	ALWAYS
SMOKE	0	2	3	4
LIGHT	0	2	3	4
AIR POLLUTION	0	2	3	4
WIND	0	2	3	4
PC SCREEN	0	2	3	4
HEATER	0	2	3	4
AC	0	2	3	4
CONTACT LENSES	0	2	3	4
Total Score of Section 2				

Section 3: Please circle the appropriate answer for each of the following questions:

During a typical day in the past week, how often did your eyes feel discomfort?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did your eyes feel dry?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did your eyes feel gritty and scratchy?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did your eyes burn and sting?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

(Continued on the next side.)

Visual Answers Optometrists
22 High St Quorn Loughborough LE12 8DT
Tel: (01509) 414151 Fax: (01509) 551607
www.VisualAnswers.co.uk

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During a typical day in the past week, how often did your eyes feel tired?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did your vision change between clear and blurry/ foggy?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did your eyelid margins look red?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did your eyes look or feel excessively watery?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did you use artificial tears?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

During a typical day in the past week, how often did you experience dryness of the nose, mouth, or vagina?
0 Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

Total Score of Section 3: _____

Comments/Testimony

_____

_____

_____

_____

Name: _____ **Sex: F / M** **Age:** _____

Address: _____

County: _____ **Post Code:** _____

Phone: (_____) _____ **Email:** _____

I understand Visual Answers Optometrists may use this Dry Eye Survey, Comments/ Testimony in the evaluation of the effectiveness of the 90 day plan and possibly for marketing purposes so others can benefit from this treatment. Visual Answers will only use my Comments/ Testimony, first name, or initials, age and city in marketing materials and no other personal information.

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