

# Visual Answers Dry Eye Survey After 90 Day Treatment Plan



## **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
<b>Total Score of Section 1</b>				

## **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
<b>Total Score of Section 2</b>				

## **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?*

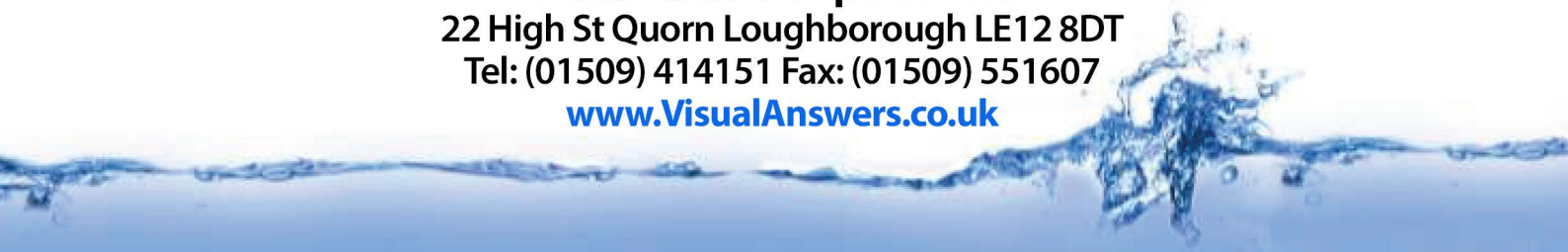
**0** Never **1** Rarely **2** Sometimes **3** Frequently **4** Constantly

*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**  
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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**

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**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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