# DRY EYE QUESTIONNAIRE (DEQ-5)*

**1.** Questions about **EYE DISCOMFORT:**

a. During a typical day in the past month, **how often** did your eyes feel discomfort?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

| NEVER HAVE IT | NOT AT ALL INTENSE | | | | VERY INTENSE |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**2.** Questions about **EYE DRYNESS:**

a. During a typical day in the past month, **how often** did your eyes feel dry?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

| NEVER HAVE IT | NOT AT ALL INTENSE | | | | VERY INTENSE |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

**3.** Questions about **WATERY EYES:**

During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

Score:

| 1a | ⊕ | 1b | ⊕ | 2a | ⊕ | 2b | ⊕ | 3 | ⊖ | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

*R. L. Chalmers et al./Contact Lens & Anterior Eye 33 (2010) 55-60

V.I.P. Laser Eye Center
Clifford L. Salinger, MD  Helayna E. Brown, MD

*"Where Vision Is Precious and Safety comes First!"*

# Dry Eye Questionaire

1. Questions about EYE DISCOMFORT:
   a. During a typical day in the past month, **how often** did your eyes feel discomfort?
      0 Never
      1 Rarely
      2 Sometimes
      3 Frequently
      4 Constantly

   b. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day,

| Never Have it | Not at All Intense | | | | Very Intense |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

2. Questions about **EYE DRYNESS**:
   a. During a typical day in the past month, how often did your eyes feel dry?
      0 Never
      1 Rarely
      2 Sometimes
      3 Frequently
      4 Constantly

   b. When your eyes felt dry**, how intense** was this feeling of dryness at the end of the day, within two hours of going to bed?

| Never Have it | Not at All Intense | | | | Very Intense |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

3. Question about **WATERY EYES:**
   During a typical day n the past month, **how often** did your eyes look or feel excessively watery?
      0 Never
      1 Rarely
      2 Sometimes
      3 Frequently
      4 Constantly

Score: 1a + 1b + 2a + 2b + 3 = Total

____ + ____ + ____ + ____ + ____ = _____

11020 RCA Center Drive ▪ Suite 2001 ▪ Palm Beach Gardens, FL 33410
Phone: 561-624-7878 ▪ Website: www.VIPLaserEyeCenter.com

**Patient Name:** _____

**Date:** _____

☐ **RIGHT EYE**

☐ **LEFT EYE**

## DRY EYE QUESTIONNAIRE - SPEED

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. **Report the type of SYMPTOMS you experience and when they occur:**

| SYMPTOMS | AT THIS VISIT | | WITHIN PAST 72 HRS | | WITHIN PAST 3 MONTHS | |
|---|---|---|---|---|---|---|
| | YES | NO | YES | NO | YES | NO |
| Dryness, Grittiness or Scratchiness | | | | | | |
| Soreness or Irritation | | | | | | |
| Burning or Watering | | | | | | |
| Eye Fatigue | | | | | | |

2. **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

3. **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 does not interfere with my day
**3** = Bothersome – irritating and interferes with my day
**4** = Intolerable – unable to perform my daily tasks

4. **Do you use eye drops for lubrication?** ☐ YES ☐ NO **If yes, how often?** _____