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

*"Where **V**ision **I**s **P**recious and Safety comes First!"*

Clifford L. Salinger, MD - Ramsey Elhosn, MD

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 <u>SYMPTOMS</u> 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 <u>FREQUENCY</u> 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 <u>SEVERITY</u> 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?** _____