DryEye-Q Test - Dry Eye Center of Maryland

1. **Circle the number that best describes your condition and enter the number in the adjacent Score column.**

How often do you have these eye problems?	never	sometimes	frequently	always	score
Redness	0	3	4	5	___
Sandy or Gritty Sensation	0	4	5	6	___
Itching	0	3	4	5	___
Excess Watering	0	3	4	5	___
Burning	0	4	5	6	___
Excess Mucous	0	3	4	5	___
Blurred Vision (corrected by blinking)	0	4	5	4	___

Are your eyes sensitive to these conditions?	never	sometimes	frequently	always	score
Smoke	0	2	3	4	___
Light	0	2	3	4	___
Air Pollution	0	2	3	4	___
Wind	0	2	3	4	___
Computer Screens	0	2	3	4	___
Heaters	0	2	3	4	___
Air Conditioning	0	2	3	4	___
Contact Lenses	0	2	3	4	___

How often do you use these medications?	never	sometimes	frequently	always	score
Anti-Depressants	0	1	2	3	___
Redness Reducing Eye Drops	0	1	2	3	___
Decongestants	0	1	2	3	___
Antihistamines	0	1	2	3	___
Blood Pressure Medication	0	3	4	5	___
Artificial Tears	0	1	2	3	___
Hormones	0	1	2	3	___
Oral Contraceptives	0	1	2	3	___
Diuretics	0	1	2	3	___
Ulcer medications	0	1	2	3	___
Tranquilizers	0	1	2	3	___
Beta Blockers	0	1	2	3	___
Incontinence Therapies	0	1	2	3	___

How often do you have these eye problems?	yes	no	score
Redness	2	0	___
Sandy or Gritty Sensation	2	0	___
Itching	2	0	___
Excess Watering	2	0	___
Burning	2	0	___
Excess Mucous	2	0	___
Blurred Vision (corrected by blinking)	2	0	___
Are you over age 50?	**5**	**0**	___
Do you experience contact lens discomfort?	**4**	**0**	___
Are you post menopausal?	**5**	**0**	___
Do you get eye strain?	**4**	**0**	___
Do you blink you eyes excessively?	**4**	**0**	___
Are you considering Refractive surgery? (i.e. RK, PRK, LASIK, LTK)	**5**	**0**	___

2. **Total the numbers in the Score column. If your score was 30 or higher, or you suspect you have Dry Eye Syndrome, contact us for a consultation.**

____________ **Total**