Appt Time: _____

Doctor: _____

**Patient Name**: _____ New / Estab

DOB: _____ Dilation / Optomap / Neither

**Service Type**: Exam CL Eval. CL F/U RX Check Office Visit Ortho K Consult LASIK DE testing

Lipiflow GLC Eval Other/Referral: _____

**Medical Insurance**: _____ Co-pay: _____

Routine coverage? Y N Deduct met? Y N If no, amount remaining: _____

**Vision Insurance**: _____ Co-pay: _____

Eligible Services: _____

**Patient Section**

Report the **FREQUENCY** of the symptoms using the numbering system below:

(Circle one) 0= Never, 1=Sometimes, 2=Often, 3=Constant

| SYMPTOMS | | | | |
|---|---|---|---|---|
| Dryness, Grittiness or Scratchiness | 0 | 1 | 2 | 3 |
| Soreness or Irritation | 0 | 1 | 2 | 3 |
| Burning or Watering | 0 | 1 | 2 | 3 |
| Eye Fatigue | 0 | 1 | 2 | 3 |

Report the **SEVERITY** of your symptoms using the rating list below:

(circle one) 0=No Problems, 1=Tolerable, 2=Uncomfortable, 3=Bothersome, 4=Intolerable

| SYMTOMS | | | | | |
|---|---|---|---|---|---|
| Dryness, Grittiness or Scratchiness | 0 | 1 | 2 | 3 | 4 |
| Soreness or Irritation | 0 | 1 | 2 | 3 | 4 |
| Burning or Watering | 0 | 1 | 2 | 3 | 4 |
| Eye Fatigue | 0 | 1 | 2 | 3 | 4 |

Do you use drops and/or ointment? Y / N How Often? _____

What drops and/or ointment do you use? _____

**Indicate time spent:**

On a computer at work: _____ hours per day

On a computer at home: _____ hours per day

On a handheld computer (e.g. smartphone, tablet): _____ hours per day

**How long have you been treated for dry eye disease?**

____ Never ____ Less than one year ____ 1-2 years ____ More than 2 years

**Do you experience any of the following symptoms?** (please check any that apply)

____ Dry Mouth ____ Muscle weakness or numbness in arms/legs ____ Fatigue

____Body Aches ____ Inability to concentrate ____ GI Distress ____ None

**Have you or a family member ever been diagnosed with an autoimmune disease such as Lupus, Rheumatoid Arthritis, Sjogren's or other associated autoimmune disease?**

____ No ____ Myself ____ Family Member, please list: _____

**Are you experiencing any of the following symptoms while at your computer monitor or using handheld devices?**

Check those that apply:

____ Headaches ____Trouble changing focus from near to far

____ Double Vision ____ Glare (light) sensitivity

____ Sore/tired eyes (eye strain) ____ Back pain

____ Burning, irritation, itchy ____ Neck and shoulder pain

____ Dry or watery eyes ____ None apply

**For Office use only:**

Total **SPEED** score (Frequency + Severity) = _____