ADVANCED VISION CARE

NICOLE FRAM MD

SAMUEL MASKET MD

JULIET CHUNG MD

STEVEN NAIDS MD

JENNIFER DANG OD

RYAN VIKESLAND OD

PATIENT NAME ____DATE: __________

Have you ever been told you have dry eyes?

☐ Yes ☐ No When? ______________Which Eye or both? ___________

Do you have any of the following symptoms?

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excess tearing/watering eyes
- ☐ Tired eyes, eye fatigue
- ☐ Stringy mucus discharge
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand /gritty feeling

Have you had any of the following surgeries?

Cataract YES/NO **Glaucoma** YES/NO **Refractive surgery** YES/NO

Do you use?

- ☐ Contact lenses
- ☐ Over the counter eye drops such as artificial tears?
- ☐ Restasis
- ☐ Rx eye drops for Glaucoma (e.g., Xalatan, Timolol)
- ☐ Rx eye drops for allergy (e.g.,anti-inflmmatory, antihistamine)
- ☐ Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following conditions?

- ☐ Windy Conditions
- ☐ Places with low humidity (e.g., airplanes/hospital)
- ☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

- ☐ Antihistamines/Decongestants
- ☐ Antidepressant or anti-anxiety
- ☐ Hormone Replacement Therapy
- ☐ Antihypertensive (e.g., Diuretic.)
- ☐ Accutane or other oral treatment for acne