DRY EYE QUESTIONNAIRE

Patient Name: Date:

Do you experience any of the following? (Check all that apply)

- Tearing/Watery Eyes
- Redness
- Burning
- Sticky/Goopy Eyes
- None of the above

Are you currently using any eye drops? ☐ Yes ☐ No

If yes, which one and how often?

Do you experience heaviness in your eyelids? ☐ Yes ☐ No

Would you like your eyes to appear more white, bright, and healthy? ☐ Yes ☐ No

Do your eyes feel chronically tired? ☐ Yes ☐ No

Do you experience allergies? ☐ Yes ☐ No

TOTAL VISION™