

# Dry eye work-up

Milton M. Hom, OD, FAAO, Jerry R. Paugh, OD, PhD,  
 Jack L. Schaeffer, OD, Paul Karpecki, OD, FAAO, Kelly  
 K. Nichols, OD, MPH, PhD. Donald Korb, OD, FAAO. Kirk  
 Smick, OD, FAAO. Shelley Cutler, OD, FAAO.

Patients: please fill out form to page 2 dotted line

**Patient Name:**

**Date:**

Subjective: demographics and history	
Subject's Date of Birth: ___ / ___ / ___      Age ____ mm    dd    yy Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female      Ethnicity:	
<b>1. Special considerations: please check all that apply:</b> <input type="checkbox"/> Pregnant or nursing <input type="checkbox"/> Tobacco user <input type="checkbox"/> Air travel more than 2x per month <input type="checkbox"/> Routinely use ceiling fan in bedroom <input type="checkbox"/> Ocular surgery (LASIK, PRK, cataract surgery) <input type="checkbox"/> Computer use more than 1 hour/day <input type="checkbox"/> Allergies	
<b>2. Systemic medications (check all that apply):</b> <input type="checkbox"/> Birth control pills <input type="checkbox"/> Beta blockers <input type="checkbox"/> Diuretics "water pills" (LASIX) <input type="checkbox"/> Antihistamines <input type="checkbox"/> Anti-depressants <input type="checkbox"/> Hormonal replacement therapy <input type="checkbox"/> Nasal corticosteroids (Flonase, Nasacort) <input type="checkbox"/> Fosamax	
<b>3. Ocular medications:(check all that apply):</b> <input type="checkbox"/> Glaucoma drops <input type="checkbox"/> Allergy drops <input type="checkbox"/> Restasis	
<b>4. Do you use artificial tears?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>5. If yes, how many times a day do you need them:</b> <input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> > 4x/day <b>6. If yes, what type of artificial tears do you use?:</b> <input type="checkbox"/> Refresh tears <input type="checkbox"/> Refresh Liquigel <input type="checkbox"/> Refresh Endura <input type="checkbox"/> Refresh Dry Eye Therapy <input type="checkbox"/> Systane <input type="checkbox"/> Systane Free <input type="checkbox"/> Visine <input type="checkbox"/> TheraTears <input type="checkbox"/> Other <b>7. Have you been diagnosed with dry eye?</b> <input type="checkbox"/> yes <input type="checkbox"/> no	<b>8. Do you think you have dry eye?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>8a. Do you have dry nasal passages or dry mouth?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>9. Previous dry eye treatments:</b> (AT, punctal occlusion, nutraceuticals, lid scrubs/massages, Restasis, etc.): <b>10. Successful (describe)?</b>
<b>11. Contact lens wear</b> <input type="checkbox"/> yes <input type="checkbox"/> no If yes, Lens and lens care information: <b>11a. Are you using contact lens rewetter?</b> <input type="checkbox"/> yes <input type="checkbox"/> no If yes, type of drop and how often? <b>12. Number of comfortable wearing hours:</b> _____ <b>13. Do you have dry eye symptoms when not wearing lenses?</b> <input type="checkbox"/> yes <input type="checkbox"/> no	<b>14. Which of the following conditions have you been diagnosed with? (check all that apply):</b> <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Lupus <input type="checkbox"/> Acne Rosacea <input type="checkbox"/> Sleep disorders <input type="checkbox"/> Sarcoid <input type="checkbox"/> Facial Herpes Zoster (Shingles) <input type="checkbox"/> MS <input type="checkbox"/> Sjogren's syndrome <input type="checkbox"/> Psoriasis <input type="checkbox"/> Acne <input type="checkbox"/> seborrhea
<b>15. How often do you experience dryness? Choose one:</b> None    Sometimes    Frequently    Always	
<b>Notes:</b>           	

# Dry eye work-up

Milton M. Hom, OD, FAAO, Jerry R. Paugh, OD, PhD,  
 Jack L. Schaeffer, OD, Paul Karpecki, OD, FAAO, Kelly  
 K. Nichols, OD, MPH, PhD. Donald Korb, OD, FAAO. Kirk  
 Smick, OD, FAAO. Shelley Cutler, OD, FAAO.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Subjective: Symptomatology

1. Do your eyes ever feel dry?  
 Never  Rarely  Sometimes  Often  All of the time \_\_\_\_\_
2. Do you ever feel a gritty or sandy sensation in your eye?  
 Never  Rarely  Sometimes  Often  All of the time \_\_\_\_\_
3. Do your eyes ever have a burning sensation?  
 Never  Rarely  Sometimes  Often  All of the time \_\_\_\_\_
4. Are your eyes ever red?  
 Never  Rarely  Sometimes  Often  All of the time \_\_\_\_\_
5. Do you notice much crusting on your lashes?  
 Never  Rarely  Sometimes  Often  All of the time \_\_\_\_\_
6. Do your eyes ever get stuck shut in the morning?  
 Never  Rarely  Sometimes  Often  All of the time \_\_\_\_\_

1. Which symptom is the worst?: \_\_\_\_\_

2. Which symptom is the most bothersome?: \_\_\_\_\_

3. Do you have teary eyes?

yes  no

**Total:** \_\_\_\_\_

(score of greater than 7 indicates dry eye)

Scoring: Never = 0, Rarely = 1, Sometimes = 2, Often = 3, All of the time = 4.

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						

Patients: please stop here

## Objective: Testing

**Visual Acuity:** (spectacles / unaided; circle one)

OD \_\_\_\_\_ OS \_\_\_\_\_

**Fluorescein Tear Breakup Time:** < 7 seconds is possibly dry/unstable

OD \_\_\_\_, \_\_\_\_, \_\_\_\_ Average \_\_\_\_ (secs)

OS. \_\_\_\_, \_\_\_\_, \_\_\_\_ Average \_\_\_\_ (secs)

**Meibomian Gland Evaluation - Expression**

OD \_\_\_\_\_ OS \_\_\_\_\_

**Expression:** 0 = normal, clear; 1 = opaque with normal viscosity; 2 = opaque with increased viscosity; 3 = severe thickening (toothpaste); 4 = no expression (glands totally blocked)

**OSDI score:** \_\_\_\_\_

## Objective: Tear volume assessment

circle one:

### Schirmer test

(amount of wetting in 5 minutes; < 5 mm = Aqueous Tear Deficiency)  
 with anesthesia                      without anesthesia

### Phenol red thread test

(amount of wetting in 15 seconds; normal >15 mm)

O.D. \_\_\_\_\_ (mm)

Tape the strips/threads

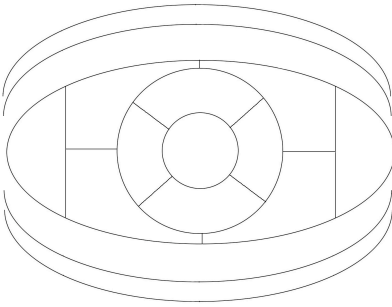
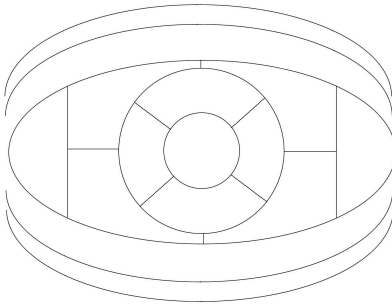
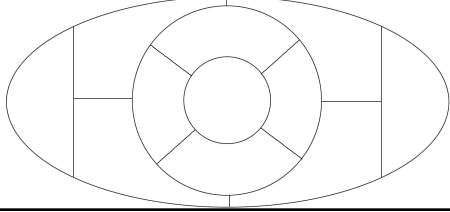
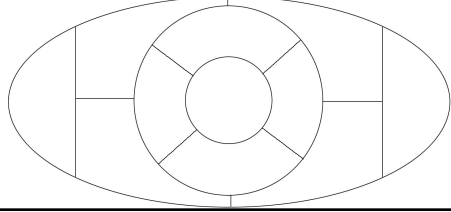
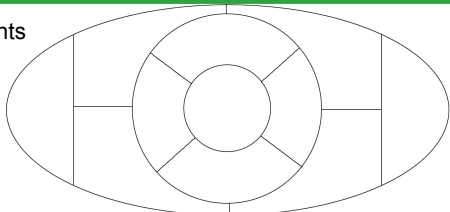
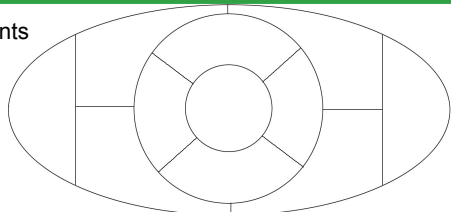
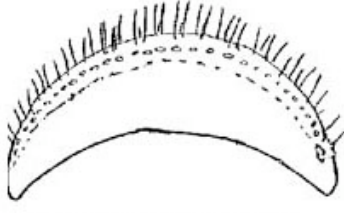
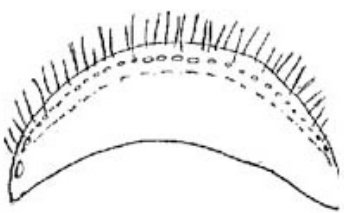
O.S. \_\_\_\_\_ (mm)

# Dry eye work-up

Milton M. Hom, OD, FAAO, Jerry R. Paugh, OD, PhD,  
 Jack L. Schaeffer, OD, Paul Karpecki, OD, FAAO, Kelly  
 K. Nichols, OD, MPH, PhD. Donald Korb, OD, FAAO. Kirk  
 Smick, OD, FAAO. Shelley Cutler, OD, FAAO.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Objective: Biomicroscopy: OD</b>		<b>Biomicroscopy: OS</b>	
			
<b>Objective: Fluorescein staining: OD</b>		<b>Fluorescein staining: OS</b>	
			
<b>Objective: Lissamine green/rose bengal staining: OD</b>		<b>Lissamine green/rose bengal staining: OS</b>	
<input type="checkbox"/> Filaments 			<input type="checkbox"/> Filaments 
<b>Objective: Lid Wiper Epitheliopathy: OD</b>		<b>Lid Wiper Epitheliopathy: OS</b>	
 <p>Width: 25% 50% 75% 100%                  Length: _____ mm                  Severity: Grade 1 2 3                  ___ % NaFl ___ % RB ___ % LG</p>	<p><b>DROP</b> _____</p> <p>_____ minutes post</p> <p><b>DROP</b> _____</p> <p>_____ minute post</p> <p><b>DROP</b> _____</p>	 <p>Width: 25% 50% 75% 100%                  Length: _____ mm                  Severity: Grade 1 2 3                  ___ % NaFl ___ % RB ___ % LG</p>	

# Dry eye work-up

Milton M. Hom, OD, FAAO, Jerry R. Paugh, OD, PhD,  
 Jack L. Schaeffer, OD, Paul Karpecki, OD, FAAO, Kelly  
 K. Nichols, OD, MPH, PhD. Donald Korb, OD, FAAO. Kirk  
 Smick, OD, FAAO. Shelley Cutler, OD, FAAO.

Patient Name:

Date:

## Objective: Additional testing

**NIBUT using Xeroscope, Keratometer or Topographer** (average of three readings; 30 secs between readings)

O.D. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Average \_\_\_\_\_ **Note:** < 10 secs = unstable tear film

O.S. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Average \_\_\_\_\_

**Tear Meniscus Height** (mm, measured with reticule eyepiece; > 0.10 mm = normal)

O.D. \_\_\_\_\_ (mm) O.S. \_\_\_\_\_ (mm)

puncta: normal stenosed punctoplasty reflux puncta: normal stenosed punctoplasty reflux

## Assessment

Dry Eye Syndrome \_\_\_\_\_

Lagophthalmos \_\_\_\_\_

Rosacea \_\_\_\_\_

Corneal involvement \_\_\_\_\_

Meibomian gland dysfunction \_\_\_\_\_

Conjunctival involvement \_\_\_\_\_

Blepharitis \_\_\_\_\_

Allergic Conjunctivitis \_\_\_\_\_

LWE \_\_\_\_\_

## Plan: treatment and management

Artificial tears \_\_\_\_\_

Ointment \_\_\_\_\_

Restasis \_\_\_\_\_

Steroids \_\_\_\_\_

Lid Scrubs \_\_\_\_\_

Hot Compresses \_\_\_\_\_

Contact lenses \_\_\_\_\_

Punctal plugs \_\_\_\_\_

Doxycycline \_\_\_\_\_

Glasses \_\_\_\_\_

Sunglasses \_\_\_\_\_

Night Goggles \_\_\_\_\_

Sport Glasses \_\_\_\_\_

Humidifier \_\_\_\_\_

Disc Fans \_\_\_\_\_

Vitamins \_\_\_\_\_

Omega 3 \_\_\_\_\_

Lid tape \_\_\_\_\_