

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:	
1. Special considerations: please check all that apply: <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	
2. Systemic medications (check all that apply): <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	
3. Ocular medications:(check all that apply): <input type="checkbox"/> Glaucoma drops <input type="checkbox"/> Allergy drops <input type="checkbox"/> Restasis	
4. Do you use artificial tears?: <input type="checkbox"/> Yes <input type="checkbox"/> No 5. If yes, how many times a day do you need them: <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 6. If yes, what type of artificial tears do you use?: <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 7. Have you been diagnosed with dry eye? <input type="checkbox"/> yes <input type="checkbox"/> no	8. Do you think you have dry eye? <input type="checkbox"/> yes <input type="checkbox"/> no 8a. Do you have dry nasal passages or dry mouth? <input type="checkbox"/> yes <input type="checkbox"/> no 9. Previous dry eye treatments: (AT, punctual occlusion, nutraceuticals, lid scrubs/massages, Restasis, etc.): 10. Successful (describe)?
11. Contact lens wear <input type="checkbox"/> yes <input type="checkbox"/> no If yes, Lens and lens care information: 11a. Are you using contact lens rewetter? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, type of drop and how often? 12. Number of comfortable wearing hours: _____ 13. Do you have dry eye symptoms when not wearing lenses? <input type="checkbox"/> yes <input type="checkbox"/> no	14. Which of the following conditions have you been diagnosed with? (check all that apply): <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
15. How often do you experience dryness? Choose one: None Sometimes Frequently Always	
Notes: 	

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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 _____

Meibomian Gland Evaluation - Expression

OD _____ OS _____

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

OD ____, ____, ____ Average ____ (secs)

OS. ____, ____, ____ Average ____ (secs)

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

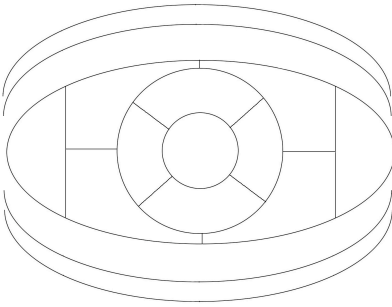
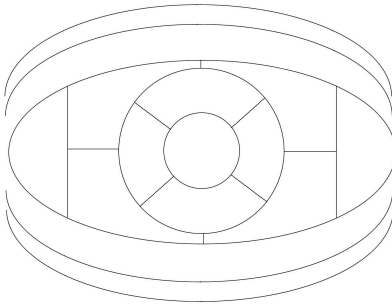
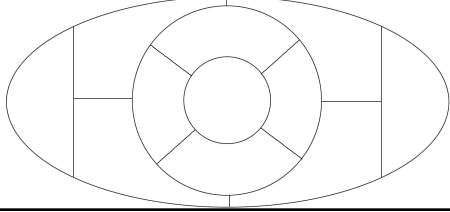
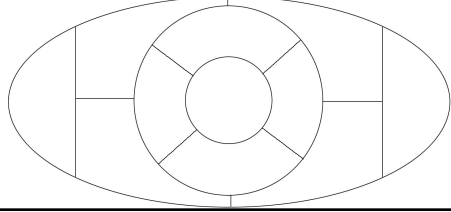
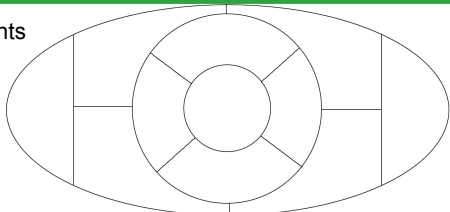
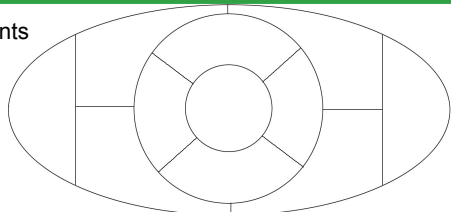
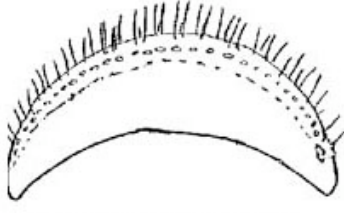
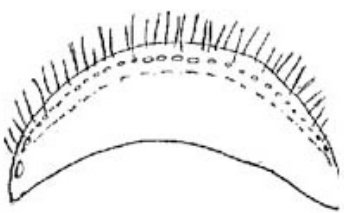
O.S. _____ (mm)

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Patient Name: _____

Date: _____

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

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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 _____

Glasses _____

Ointment _____

Sunglasses _____

Restasis _____

Night Goggles _____

Steroids _____

Sport Glasses _____

Lid Scrubs _____

Humidifier _____

Hot Compresses _____

Disc Fans _____

Contact lenses _____

Vitamins _____

Punctal plugs _____

Omega 3 _____

Doxycycline _____

Lid tape _____