

# Questionnaire

Questions	Yes	No
1. Do you feel like you have something in your eye?	<input type="checkbox"/>	<input type="checkbox"/>
If yes does it feel better when your rub it?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your vision seem to fluctuate when you read?	<input type="checkbox"/>	<input type="checkbox"/>
If yes does it get better when you blink?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your vision ever blur?	<input type="checkbox"/>	<input type="checkbox"/>
Does it clear up when you blink and then blur again?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do your eyes feel stuck shut in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Does washing or rubbing your eyes seem to help them feel better?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you suffer from frequent styes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do your eyes tear or water?	<input type="checkbox"/>	<input type="checkbox"/>
Is the tearing worse: (Please check all that apply)	<input type="checkbox"/>	<input type="checkbox"/>
Outside or inside?	<input type="checkbox"/>	<input type="checkbox"/>
In air conditioning?	<input type="checkbox"/>	<input type="checkbox"/>
On a windy day?	<input type="checkbox"/>	<input type="checkbox"/>
Using the computer?	<input type="checkbox"/>	<input type="checkbox"/>
In a smoke filled area?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently use any type of artificial tear?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do your eyes burn?	<input type="checkbox"/>	<input type="checkbox"/>
When does it start? _____		
How long does it last? _____		
9. Do your eyes get tired?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do your eyes feel soar when blinking or moving your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have sensitivity to bright lights or sunshine?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do your eyes itch?	<input type="checkbox"/>	<input type="checkbox"/>
13. Are your lids usually red or puffy?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have frequent eye infections?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have discharge from your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had eyelid surgery?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury to your eyelids?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
How long do you wear your contact lenses? _____		
Do you wear them overnight?	<input type="checkbox"/>	<input type="checkbox"/>
19. Are your lenses comfortable?	<input type="checkbox"/>	<input type="checkbox"/>
20. Are your eyes sensitive to contact lens solution?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you worn contact lenses before but quit wearing them due to discomfort?	<input type="checkbox"/>	<input type="checkbox"/>