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North Raleigh Family Eyecare

1. Circle the number that best describes your condition and enter the number in the adjacent score column.

How often do you have these eye problems?	NEVER	SOMETIMES	FREQUENTLY	ALWAYS	SCORE
Redness	0	0	0	0	
Sandy or Gritty Sensation	0	0	0	3	
Itching	4	3	3	4	
Excess Watering	3	4	4	5	
Burning	4	4	5	4	
Excess Mucous	5	5	6	5	
Blurred Vision (corrected by blinking)	5	6	5	4	
Are your eyes sensitive to these conditions?	**NEVER**	**SOMETIMES**	**FREQUENTLY**	**ALWAYS**	**SCORE**
Smoke	0	2	3	4	
Light	0	2	3	4	
Air Pollution	0	2	3	4	
Wind	0	2	3	4	
Computer Screens	0	2	3	4	
Heaters	0	2	3	4	
Air Conditioning	0	2	3	4	
Contact Lenses	0	2	3	4	
How often do you use these medications?	**NEVER**	**SOMETIMES**	**FREQUENTLY**	**ALWAYS**	**SCORE**
Anti-Depressants	0	1	2	3	
Redness Reducing Eye Drops	0	1	2	3	
Decongestants	0	1	2	3	
Antihistamines	0	1	2	3	
Blood Pressure Medication	0	3	4	5	
Artificial Tears	0	1	2	3	
Hormones	0	1	2	3	
Oral Contraceptives	0	1	2	3	
Diuretics	0	1	2	3	
Ulcer medications	0	1	2	3	
Tranquilizers	0	1	2	3	
Beta Blockers	0	1	2	3	
Incontinence Therapies	0	1	2	3	
How often do you have these eye problems?			**YES**	**NO**	**SCORE**
Redness			2	0	
Sandy or Gritty Sensation			2	0	
Itching			2	0	
Excess Watering			2	0	
Burning			2	0	
Excess Mucous			2	0	
Blurred Vision (corrected by blinking)			2	0	
Are you over age 50?			5	0	
Do you experience contact lens discomfort?			4	0	
Are you post menopausal?			5	0	
Do you get eye strain?			4	0	
Do you blink your eyes excessively?			4	0	
Are you considering Refractive surgery (i.e. Lasik)			5	0	

TOTAL:

2. Total numbers in the Score column. If your score was 30 or higher, or you suspect you have Dry Eye Syndrome, contact us for a consultation.