Ocular Surface Health Questions

Please check all symptoms experienced since last visit

☐Dry Eyes
☐Blurry Vision
☐Redness
☐Burning
☐Itching
☐Light Sensitivity
☐Excessive tearing/watery eyes
☐Tired eyes/eye fatigue
☐Stringy mucous in or around the eyes
☐Foreign Body Sensation/Gritty Scratchy, feeling of sand or grit in eye

Have you used eye drops in the last 2 hours?
Yes☐No☐

Does your vision change throughout the day?
Yes☐No☐

Can you wear your contacts comfortably as long as you'd like?
Yes ☐No☐

Sleep Apnea

Do you wake up in the morning with a headache?
Yes ☐☐No

Do you find it necessary to take a nap in the afternoon?
Yes☐No☐

Do you snore?
Yes☐No☐

Rosacea

Does your face flush easily, eating spicy foods, alcohol, or hot showers?
Yes☐ No☐

Do you have bloating with certain foods?
Yes☐No ☐

If so, which ones?

☐Light colored eyes/and or skin
☐Cardiovascular disease
☐Difficulties driving at night
☐Difficulty distinguishing an object from a similar color background (dark car on a dimly lit street)

Macular Pigment Ocular Density Questions

Please check all that apply

☐Family history of AMD or taken a genetic test (23 & Me) and tested for an AMD risk
☐Outdoor occupation or excessive computer use (2+ hours per day)
☐Bright light sensitivity
☐Current or former smoker
☐Low vegetable intake (< 5 servings/day)

External Exam

Would you like your eyes to be more open?

Yes☐ **No☐**

Are there any areas around your eyes that you wish could be changed such as wrinkles, dark spots or texture? Do people comment that you look tired or angry, etc?

Yes☐ **No☐**