

NAME _____

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
- Contact lens discomfort
- Scratchy, feeling of sand or grit in eye
- Fluctuating vision

Have you ever treated yourself for dry eyes? Yes No

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

**FOR OFFICE
USE ONLY**

Initials of Ordering Physician _____ Date _____

OSMOLARITY MEASUREMENTS

Right Eye (OD) _____ (mOsm/L) Left Eye (OS) _____ (mOsm/L)

Inter-eye difference is >8 mOsm/L Yes No

Osmolarity Normal Abnormal

Patient dry eye severity Mild Moderate Severe

Schedule for dry eye workup Yes No



300

320
(mOsm/L)

340