TOTAL VISION Family Eye Care

OCULAR SURFACE DISEASE EXTENDED HISTORY

Name: _____ **Date of Birth:** _____

In preparation for your ocular surface evaluation and consultation, please provide the following medical and lifestyle information. Your answers will help the doctor understand the course of your condition and guide treatment options.

SYMPTOMS

Please circle the words that describe your symptoms:

☐ Burning ☐ Dry ☐ Mattering ☐ Irritated ☐ Redness ☐ Fatigue / Tired

☐ Blurry ☐ Sore ☐ Watering ☐ Itching ☐ Gritty / Sandy ☐ Other _____

In your own words, please describe symptom onset and how your eyes feel most days:

Example: When did you first notice your symptoms? One eye? Both eyes? Constant or intermittent? Are you more symptomatic at certain times of the day (e.g. late afternoon, when you wake up) or location (e.g. work, home.)?

What drops, gels, ointments or other treatments do you currently use? Please list how often you use the treatments and brand name if known.

Example: Systane Balance, twice a day

Which of the above treatments provide relief? To what degree (e.g. 50%)? For how long (e.g. 1-2 hours)?

Example: The Systane Balance helps about 50% for about 2 hours.

If you can recall, it would be helpful to know what drops, gels, ointments or procedures (e.g. Restasis, plugs, Lipiflow, IPL) that you have tried previously:

Example: I've tried some type of fish oil and Restasis

SYMPTOMS THAT MAY BE ASSOCIATED WITH OCULAR SURFACE DISEASE

Please check any boxes that apply:

☐ Dry Mouth
☐ Fatigue
☐ Body Aches
☐ Dry Nose/Nosebleeds
☐ Numbness of arms/legs
☐ GI Distress (IBS, Crohn's, etc.)
☐ Dry skin or other skin conditions (please list) _____
☐ Joint pain (please list joints that hurt) _____
☐ History of acne treatment (e.g. Accutane®, Retin-A®, Renova®)
☐ Other symptoms that concern you: _____

AESTHETIC & SKIN CARE HISTORY

Have you had permanent eyeliner applied/tattooed? ☐ YES ☐ NO
Have you used lash extensions (or considering in the future)? ☐ YES ☐ NO
Are you using a lash lengthening serum? ☐ YES ☐ NO
Have you used, or planning to use, injectables or fillers (e.g. Botox, Dysport, Xeomin, Juvederm, etc.) ☐ YES ☐ NO
Have you had any eyelid or facial surgery? YES ☐ NO ☐

CONTACT LENS HISTORY *(WE WANT TO OPTIMIZE YOUR COMFORT)*

1. **Do you currently wear contact lenses?** _____ *If yes, please answer questions 3-7.*
2. **Have you tried contact lenses but unable to continue due to comfort?** _____
3. **How many hours/day?** _____
4. **How many days/week?** _____
5. **How many hours can you wear your contact lenses prior to noticing a decline in comfort or feel the need to use eye drops?** _____
6. **What cleaning system do you use (if not using single use lenses)?** _____
7. **How often do you insert a fresh lens?** _____

VITAMINS & SUPPLEMENTS

Please list any vitamins or nutritional supplements you take on a regular basis:

VERY IMPORTANT - PLEASE BRING PRODUCTS WITH YOU TO YOUR APPOINTMENT OR TAKE PHOTOS OF PRODUCT FRONT AND BACK LABELS. YOU MAY ALSO CHOSE TO LIST PRODUCTS BELOW.

Product:	Dose:

LIFESTYLE

Many factors impact our tear production, from what we eat and drink to our jobs and hobbies, all can play a role in our symptoms. Small lifestyle modifications often contribute to relief.

- How many ounces of water do you drink per day? _____
- How many caffeinated drinks per day (e.g. coffee, tea, energy drinks)? _____
- Do you drink soda or diet soda? _____
- On average, how many beverages containing alcohol (beer, wine, spirits) do you consume per week? _____
- Do you (or a bed partner) use a c-pap device? _____
- Do you use ceiling fan(s)? _____
- Do you frequently drive long distances for work or pleasure? _____
- Do you travel by airplane? If so, how many trips per year? _____
- Does your workplace create any environmental challenges (e.g. fans, no air conditioning, etc.)? _____
- How many hours of sleep do you average? _____

Check the boxes that apply if you use any of the following products that are known to be associated with dry eye symptoms:

☐ Cigarettes (Tobacco Products) ☐ Vape ☐ Cannabis (Smoking / Edibles)

HORMONE RELATED TEAR PRODUCTION

Our hormones play many roles in our body, including tear production. Please list any hormone-related issues past or present.

e.g. thyroid disease, irregular periods, PCOS, menopause, low testosterone, adrenal insufficiency or exhaustion, use of birth control (e.g. oral contraceptives, IUD's), synthetic or biodentical hormones

Are you, or could you, be pregnant? ☐ YES ☐ NO ☐ UNSURE