NEW PATH VISION
PERSONALIZED EYE CARE | POTTSTOWN, PENNSYLVANIA

THE DRY EYE CENTER AT NEW PATH VISION
1100 Heritage Drive, Suite A, Pottstown, PA 19464
610-326-2754 | pottstown@newpathvision.com

Dry Eye Center Intake Questionnaire

Help us understand your symptoms, triggers and prior treatment.

PATIENT AND SYMPTOM OVERVIEW

Patient name

Date of birth

When did your symptoms begin?

Symptoms usually affect ☐ One eye ☐ Both eyes

Symptoms (check all that apply):

- ☐ Dryness
- ☐ Burning / stinging
- ☐ Gritty / sandy feeling
- ☐ Redness
- ☐ Excessive tearing
- ☐ Fluctuating / blurry vision
- ☐ Eye fatigue
- ☐ Light sensitivity
- ☐ Mucus / stringy discharge
- ☐ Contact lens discomfort
- ☐ Heavy / tired eyelids
- ☐ Frequent blinking

Overall severity (0-10)

How often?

Worst time of day

TRIGGERS AND ENVIRONMENT

- ☐ Computer / screen use
- ☐ Reading
- ☐ Driving
- ☐ Air conditioning / heat
- ☐ Wind / outdoor exposure
- ☐ Air travel
- ☐ Contact lens wear
- ☐ Makeup / cosmetics
- ☐ Allergy season
- ☐ Morning
- ☐ Late day / evening
- ☐ After eye surgery

Average screen time per day

Contact lens wear hours/day

CPAP use? ☐ Yes ☐ No

What bothers you most or limits you most?

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Prior care and health factors

TREATMENTS YOU HAVE TRIED

- ☐ Artificial tears / lubricants
- ☐ Gel / ointment
- ☐ Prescription dry-eye drops
- ☐ Warm compresses
- ☐ Lid scrubs / lid hygiene
- ☐ Omega-3 supplements
- ☐ Punctal plugs
- ☐ IPL / light-based treatment
- ☐ Thermal / gland treatment
- ☐ Allergy drops
- ☐ Steroid eye drops
- ☐ Other

Which treatments helped? Which did not?

CURRENT EYE PRODUCTS

Eye drop / product 1	**How often?**
Eye drop / product 2	**How often?**
Eye drop / product 3	**How often?**
Eye drop / product 4	**How often?**

MEDICAL FACTORS THAT MAY AFFECT THE OCULAR SURFACE

- ☐ Autoimmune disease
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Rosacea
- ☐ Seasonal / environmental allergies
- ☐ Migraine
- ☐ Sleep apnea
- ☐ Prior LASIK / refractive surgery
- ☐ Cataract surgery
- ☐ Glaucoma medication use
- ☐ Menopause / hormonal change
- ☐ Other

Relevant medications (especially antihistamines, antidepressants, acne medicines, diuretics, glaucoma drops, etc.)

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Goals and visit preparation

CONTACT LENS AND EYEWEAR IMPACT

Do you wear contact lenses? ☐ Yes ☐ No

If yes, describe comfort and how long you can wear them

YOUR GOALS

- ☐ Less burning / irritation
- ☐ Better computer comfort
- ☐ Reduce excessive tearing
- ☐ Improve morning comfort
- ☐ Understand the cause
- ☐ More stable vision
- ☐ Wear contacts more comfortably
- ☐ Reduce redness
- ☐ Improve end-of-day comfort
- ☐ Other

What would make this visit successful for you?

Before your Dry Eye Center visit

- Bring the eye drops, lid products, supplements or medications you currently use, or a current list.
- Bring your contact lenses and glasses if they are part of the problem.
- Tell us about recent eye surgery, medication changes or new systemic symptoms.

Screening note

This questionnaire helps organize symptoms and history. It does not diagnose dry eye or exclude other eye conditions. Sudden vision loss, severe pain, new flashes/floaters, significant injury or other urgent symptoms require prompt clinical evaluation.