Box Medical Solutions Inc

Patient Name: DOB:

www.boxmedicalsolutions.com Date: ID:

General Eye Questions			
• When did your dry eye symptoms begin?	__months / years prior		
• What time of day is your dryness worst?	Morning/evening		
• Do you take allergy eye drops?		Yes	No
• Do you take glaucoma eye drops?		Yes	No
• Have you had any recent eye infections?		Yes	No
Refractive Surgery			
• Have you ever had refractive surgery (e.g. LASIK, PRK)?		Yes	
• Did you have complications from the refractive surgery?		Yes	No
Contact lenses			
• Do you currently wear contact lenses?		Yes	No
• Is your dryness worse when you wear contacts?		Yes	No
• After how many hours do you experience dryness with your contacts?			
• How often do you discard your contacts?			
• What solution do you use to store your contacts?			
Endocrinology / Hormones			
• Are you taking oral contraceptives (birth control)?		Yes	No
• Do you or have you taken estrogen creams or hormone replacement therapy?		Yes	No
• Have you ever been diagnosed with low testosterone?		Yes	No
• Have you been diagnosed with Polycystic Ovarian Syndrome?		Yes	No
• Are you diabetic or pre-diabetic?		Yes	No
Environment			
• How many hours a day are you in front of a screen (TV, computer, tablet, etc.)?			hours/day
• How often do you take a break from screen time?			times/day
• Do your eyes feel dry during a specific season? If so, which?			
Medications:			
• Do you take any high blood pressure medications?		Yes	No
• Do you or have you taken oral acne medications?		Yes	No
• Do you take antihistamines (e.g. Claritin, Zyrtec, Allegra, Flonase)?		Yes	No
• Do you take antidepressants?		Yes	No

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Immune system		
• Do you have any of the following: dry mouth, cracked tongue, constant dry lips/nose?	Yes	No
• Do you have constant skin dryness?	Yes	No
• Do you have joint pain?	Yes	No
• Have you ever been diagnosed with an autoimmune condition?	Yes	No
• Have you ever been diagnosed with a collagen vascular disease?	Yes	No
• Have you ever been diagnosed with hepatitis C?	Yes	No
• Have you ever been diagnosed with sarcoidosis?	Yes	No
• Have you ever been diagnosed with a gastrointestinal disorder like ulcerative colitis?	Yes	No
Eyelid:		
• Do you have crusting in the morning?	Yes	No
• Do you experience burning, stinging, or itching?	Yes	No
• Have you ever had upper or lower eyelid surgery? If so, when?	Yes	No
• Do your eyes feel worse in the morning or afternoon?	Yes	No
• Has anyone told you that you sleep with your eyes open?	Yes	No
• Do your notice redness around your eyelid margins?	Yes	No
• Are your eyelids sensitive to touch?	Yes	No

Doctors Section:

Tear Meniscus Height	_____*mm*	*Lagophthalmos*	+ / -
Tear Break Up Time:	_____*seconds*	*Floppy Eyelid Syndrome*	+ / -
Blink Rate:	_____*/min*	*Blepharitis*	+ / -
Conjunctival Staining (0-4)	_____	*Demodex*	+ / -
Corneal Staining: (0-4)	_____	*Lid Telangectasia*	+ / -
Conjunctival Chalasis (0-4)	_____		

Meibography:

Meibomian Gland Grading: *RUL____ LUL____*
RLL____ LLL____

Meibomian Gland Expression: _____*(0-4)*