LivingHope VISION CLINIC

# DRY EYE QUESTIONAIRE (DEQ-5)

Date: _____ Name: _____

1. Questions about **EYE DISCOMFORT**:

a. During a typical day in the past month, **how often** did your eyes feel discomfort?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

b. When your eyes feel discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

| NEVER HAVE IT | NOT INTENSE AT ALL | | | | VERY INTENSE |
|---|---|---|---|---|---|
| 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

2. Questions about **EYE DRYNESS:**

a. During a typical day in the past month, **how often** did your eyes feel dry?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

| NEVER HAVE IT | NOT INTENSE AT ALL | | | | VERY INTENSE |
|---|---|---|---|---|---|
| 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

3. Questions about **WATERY EYES:**

a. During a typical day in the past month, **how often** did your eyes look or feel exes-sively watery?feel dry?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

**Score:**

| 1a ⊕ | 1b ⊕ | 2a ⊕ | 2b ⊕ | 3 ⊖ | TOTAL |
|---|---|---|---|---|---|
| | | | | | |

**Score > 6 indicates Dry eye**
**Take action today by bookin a Dry eye consultation**
**(905) 561-1110 · www.LHvisionclinic.com**