Nasolacrimal Questionnaire

1. How often do you experience any of the following symptoms?

	Never	Occasionally	Frequently	Constantly
Redness				
Sandy or gritty sensation				
Excess watering				
Burning				
Excess mucous discharge				
Fluctuating/blurred vision corrected with blinking				
Foreign body sensation				

2. Are your eyes sensitive to these conditions?

	Never	Occasionally	Frequently	Constantly
Smoke				
Air pollutants				
Wind				
Computer glare				
Air conditioning or heaters				
Contact Lenses				
Light				

3. How often do you use the following medications?

	Never	Rarely	As Needed	Daily
Anti-depressant				
Antihistamine				
Decongestant				
Diuretics				
Beta Blockers				
Oral Contraceptives				
Hormone Replacement therapy				
Artificial Tears				

Have you had punctal plugs inserted? ___ Yes ___ No How long ago? ___________________

Patient's signature: ___________________________________ Date: ______________________