Practice Aid

Lacrimedics
The Leader in Occlusion Therapies™

SYMPTOMS CHECKLIST

Patient Name (Print): _____ Date: _____

PLEASE NOTE: To ensure a proper Eye Health Examination indicate symptoms or conditions you now experience, or have experienced during the last 12 months. Provide complete answers.

EYE SYMPTOMS	*Right Eye* YES	*Left Eye* YES
Redness	☐	☐
Dry Eye Feeling	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Constant Tearing	☐	☐
Occasional Tearing	☐	☐
Watery Eyes	☐	☐
Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Sties, Chalazion	☐	☐
Fluctuating Visual Acuity	☐	☐
"Tired" Eyes	☐	☐
Contact Lens Discomfort	☐	☐
Contact Lens Solution Sensitivity	☐	☐
Mucous Discharge	☐	☐

SECONDARY SYMPTOMS	*YES*
Sinus or Nasal Congestion	☐
Difficulty Breathing	☐
Chronic Cough	☐
Head Congestion	☐
Post-nasal Drip	☐
Chronic Bronchitis	☐
Allergy Symptoms	☐
Hay Fever	☐
Chronic Cold Symptoms	☐
Middle Ear Congestion	☐
Sneezing	☐
Dry Mouth or Throat	☐
Headaches	☐
Asthma Symptoms	☐
Heartburn or Indigestion	☐
Snoring	☐
Sleep Apnea	☐
GERD	☐

Circle items which you are sensitive to:

Heaters	Dust
Blowers	Pollen
Air Conditioning	Airplane Cabins
Cigarette Smoke	Computer Screens
Smog	Sunshine
Contact Lens Wear	Wind

Circle conditions you or a family member (blood relative) have experienced:

Glaucoma	Diabetes
Tuberculosis	Rheumatoid
Lupus	Thyroid Disorder
Gout	Heart Disease
Cataracts	High Blood Pressure
Arthritis	Sjogren's Syndrome

	YES	
Do you use lubricating drops?	☐	What brand? _____
Do you wear contact lenses	☐	How often? _____
Are your contacts comfortable?	☐	How long have you worn them? _____
Have you tried contacts before and quit?	☐	Why? _____
Do you use glasses?	☐	How long have you had them? _____
Have you ever had an eye injury?	☐	Describe the injury: _____
Are you allergic to anything?	☐	List: _____
Do you take any medications?	☐	List: _____

Additional comments: _____

_____ _____

Patient's Signature **Doctor's Name**

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