NORTH TORONTO EYE CARE
our focus ... your vision

DRY EYE CENTRE

DRY EYE QUESTIONNAIRE: DEQ5

NAME: _____ DATE: _____

1. About your **EYE DISCOMFORT:**
   a) Other than your vision, during a typical day in the past month, **how often** did your eyes feel discomfort?

      0 [ ] Never
      1 [ ] Rarely
      2 [ ] Sometimes
      3 [ ] Frequently
      4 [ ] Constantly

   b) When your eyes felt that discomfort, **how intense was this feeling of discomfort** at the end of the days, within 2 hours of going to bed?

Never	Not at all intense				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?

      0 [ ] Never
      1 [ ] Rarely
      2 [ ] Sometimes
      3 [ ] Frequently
      4 [ ] Constantly

   b) When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within 2 hours of going to bed?

Never	Not at all intense				Very Intense
0 [ ]	1 [ ]	2 [ ]	3 [ ]	4 [ ]	5 [ ]

3. Question about **WATERY EYES:**
   a) During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

      0 [ ] Never
      1 [ ] Rarely
      2 [ ] Sometimes
      3 [ ] Frequently
      4 [ ] Constantly

OFFICE USE ONLY
TOTAL SCORE: [ ]