RESTORE DRY EYE CLINIC

DRY EYE QUESTIONAIRE (DEQ-5)

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 exessively watery?

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

Score:

1a ⊕	1b ⊕	2a ⊕	2b ⊕	3 ⊜	TOTAL
					0