QUESTIONNAIRE

First name :..... Surname :.....

Date of 1st exam : ..... / ..... / .....

1. Questions about Eye Discomfort

a. On a scale of 0 to 4, please indicate how often did you experience eye discomfort on a typical day in the past month:

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Frequently
- 4 ☐ Constantly

b. When you experienced eye discomfort, how intense was it in the two hours before bedtime as the day was winding down?0 = Never had it | 1 = Not intense at all | From 2 to 5 = please indicate the intensity (5 is very intense)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

2. Questions about dry eye :

a. On 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 you experienced dry eye discomfort, how intense was it in the two hours before bedtime as the day was winding down?

0 = Never had it | 1 = Not intense at all | From 2 to 5 = please indicate the intensity (5 is very intense)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

3. Questions about watery eyes :

On 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

SCORE :	1a	+	1b	+	2a	+	2b	+	3	=	TOTAL
	.....	+	.....	+	.....	+	.....	+	.....	=	.....

If your cumulative score exceeds 6, it is likely that you are experiencing dry eye syndrome. We recommend discussing your symptoms with an eye care specialist and considering a more comprehensive, advanced evaluation.

Please note that this questionnaire is not a substitute for a medical examination.

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