Welcome!

We want to extend our personal greetings and a very warm welcome to our practice. For 40 years, Lake Eye Associates has been committed to doing everything possible to provide you with quality and customized eye care. We hope to make not only your first visit, but all visits to our office, as pleasant and comfortable as possible.

New patient exams usually take approximately 2 hours. Generally, in the course of your first visit, you will be dilated as an important part of your complete eye examination. Most people are able to drive following dilation, but you may want to bring a driver if you have experienced problems driving after dilation in the past, or if your eyes have never been dilated. Parents of minor children should plan to stay with their child.

- At the time of your visit, please bring your completed forms, insurance cards, and a list of your current medications and dosages prescribed. If you wear contact lenses or glasses, please remember to bring them with you as well. If you do not bring your completed forms with you, you will be asked to fill them out again before being seen.

- Please arrive 15 minutes prior to your scheduled appointment time so that we may process your paperwork and scan your insurance cards.

- Enclosed with your new patient registration forms is a copy of Lake Eye Associates’ Financial Policy. Please be sure to read through it carefully as we hope it will give you a better understanding of our billing and payment process.

- If you wear contact lenses you will be scheduled for a separate appointment for a contact lens evaluation. Contact lens prescriptions will not be renewed during your complete exam with the physician.

- Please be aware that we allow a 15 minute window for late arrivals. If you arrive beyond that window your appointment will have to be rescheduled to a later date.

If you have any questions or need help with the enclosed forms, please feel free to contact any of our locations and one of our caring and professional staff members would be glad to help.

Thank you again for choosing Lake Eye Associates and we look forward to assisting in all your eye care needs.

Sincerely,
The Doctors and Staff of Lake Eye Associates
## Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Full Legal Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Age:</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Social Security Number:</td>
<td>Marital Status: (please circle)</td>
</tr>
<tr>
<td></td>
<td>Married • Widow • Single • Other</td>
</tr>
<tr>
<td>Preferred Language: (please circle)</td>
<td>Retired: [ ] Yes [ ] No</td>
</tr>
<tr>
<td>English • Spanish • Other</td>
<td>Employer:</td>
</tr>
<tr>
<td>Race: (please circle)</td>
<td>License State:</td>
</tr>
<tr>
<td>White • African American • American Indian</td>
<td>Driver’s License Number:</td>
</tr>
<tr>
<td>Asian • Decline • Other</td>
<td>License State:</td>
</tr>
<tr>
<td>Ethnicity: (please circle)</td>
<td></td>
</tr>
<tr>
<td>Not Hispanic or Latino • Latino • Decline</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Patient Home Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Additional Contact:</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Spouse’s Full Legal Name:</td>
<td></td>
</tr>
<tr>
<td>Spouse’s Phone Number:</td>
<td>Spouse’s Date of Birth:</td>
</tr>
<tr>
<td>Spouse’s Social Security Number:</td>
<td></td>
</tr>
</tbody>
</table>

### If Patient is a Minor Please Complete

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Responsible or Guardian:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Social Security Number:</td>
</tr>
<tr>
<td>Phone Number (if different):</td>
<td></td>
</tr>
<tr>
<td>Home Address (if different):</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Zip Code:</td>
</tr>
</tbody>
</table>
### Emergency Contact

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Phone Number:</th>
</tr>
</thead>
</table>

### Medical Release

Please indicate the names of those individuals with whom we may discuss your medical and non–medical information.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Non–Medical</th>
<th>Medical</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Non–Medical</th>
<th>Medical</th>
</tr>
</thead>
</table>

### Primary Insurance Information

<table>
<thead>
<tr>
<th>Insurance Carrier:</th>
<th>Policy Holder:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy #:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

### Secondary Insurance Information

<table>
<thead>
<tr>
<th>Insurance Carrier:</th>
<th>Policy Holder:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy #:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

### Vision Plan Information

<table>
<thead>
<tr>
<th>Insurance Carrier:</th>
<th>Policy Holder:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy #:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

Please provide the receptionist with your driver’s license and insurance cards so a copy can be added to your file.

### WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE

- Family/Friend
- Internet
- Billboard
- Insurance Directory
- Referring Physician
- Seminar/Screening
- Newspaper/Publication
- Yellow Pages
- Workman’s Comp
- Florida Hospital Waterman
- Leesburg Regional Medical Center
- Villages Regional Medical Center

Name of referring physician: ________________________________
REFRACTION POLICY

WHAT IS A REFRACTION

A refraction is a diagnostic test to determine best corrected vision. This test should be performed on the first visit with us, an annual visit, before cataract surgery and anytime vision decreases significantly. A refraction is a vital test to the care of the eyes because it allows for assessment of current eye health and the detection of eye diseases. A prescription maybe provided to update glasses or it may be medically necessary by insurance to determine if you qualify for certain eye procedures such as, cataract or laser eye surgery. Even though this is a vital test to the care of the eyes, a refraction is a non-covered service through Medicare, and most insurance plans. Unfortunately, they do not differentiate between "medical refractions" and refractions performed solely for the purpose of providing glasses.

WHY IS IT A NON-COVERED SERVICE

CMS, the department of the federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of the eye exam. CMS, directly under control of the US Congress, has determined this is a ‘non-covered’ service meaning you are responsible to pay for that portion of the exam.

Refraction (CPT code 92015) has been a ‘non-covered’ service since Medicare was created in 1965. As many private insurance carriers adopt the policies of Medicare, many of our contracts with private insurance require us to collect the fee as well.

A prescription maybe provided to update glasses or it may be medically necessary by insurance to determine if you qualify for certain eye procedures such as, cataract or laser eye surgery. The policy of the practice is to continue with this portion of the exam unless you tell us to stop.

ROUTINE AND MEDICAL EYE EXAMS

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with no eye problems. If the doctor detects any medical condition, (dry eyes, floaters etc.) the examination may become a medical eye examination and may be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the medical eye examination. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the examination on your visit, the doctor may ask you to return another day for a medical eye examination. Please note that some insurance plans consider a routine eye exam to be a non-covered service. Vision Plan Patients: I have read and understand the above routine eye care policy.

The fee for the refraction will be collected at the date when service was provided.

__________________________________________________________
Patient Signature Date
FINANCIAL POLICY

Welcome to our practice!
This information is being provided so that you may better understand our billing process and payment policy.
If you have any questions about your bill or the policy explained in this information, you may call our billing
department between 8:00 a.m.-5:00 p.m., Monday through Friday at (352) 343-4798.
When you arrive for your first appointment, you will be asked to complete a patient registration form. It is very
important that you provide us with accurate information and notify our office of any changes should they occur.
We will also need to make copies of any insurance cards you have.

REFRACTIONS
A refraction is a routine vision test during which you will be asked to read an eye chart, possibly through a
different set of lenses. This test determines how well you are seeing, if you need new glasses or a new
prescription. Refractions are not considered part of a medical exam and are not covered by Medicare or most
insurances. Payment for the refraction is due at the time of service.

MEDICARE
We will file your claims directly to Medicare and your secondary insurance. If you do not have insurance, your 20%
coinsurance and any remaining Medicare deductible is due at the time of service.

INSURANCE
We are participating providers for BCBS of Florida, United Healthcare, Cigna HMO, Aetna HMO just to name a
few. If we do not participate in your particular plan, we will make every effort to inform you prior to your
appointment, however, it is your responsibility as the patient to verify prior to scheduling an appointment.

No Show APPOINTMENTS
Beginning January 01, 2011 we will be assessing a $25.00 fee if you fail to show for an appointment. We will
require that you give our office a 24 hour notice for cancelled or rescheduled appointments.

CO PAYS & DEDUCTIBLES
To avoid being charged a possible statement fee, co pays, coinsurance and deductibles must be paid at the time
of service.

AUTHORIZATIONS & REFERRALS
If your insurance requires prior authorization of referral from your primary care physician, we will make every
effort to obtain this prior to your appointment. If we are unable to obtain this information, you will be
responsible for the visit.

VISION PLANS
Currently VSP and EyeMed Access Plan are the only routine vision plans we accept. If you are a member of either
plan you must notify the front desk prior to being seen. Let them know that you are here for a routine vision exam
and you wish us to bill your vision plan.

SELF PAY
If you are a self-pay patient, payment in full is due when services are rendered.
WORKER'S COMP & LIABILITY
If you are injured on the job or in an automobile accident, we will file your claim if you have provided us with the necessary information to do so. **If we do not receive payment within 45 days, you will be held responsible for the visit.**

PATIENT STATEMENTS
Patient statements are mailed on or around the 10th of each month. Payment is due upon receipt. If you have a question regarding your bill, you must contact our billing department immediately.

PAST DUE ACCOUNTS
If your balance is not paid within 30 days and you have not contacted our office to arrange payment, your account is considered past due. Our office will make every effort to assist you with settling your account. If, however, all efforts fail and you choose to ignore your obligation, we will have no choice but to pursue further action against you.

RETURNED CHECKS
If your check is returned from the bank due to "Insufficient Funds," you will be notified immediately. In addition to the amount of the check, you will be charged a $25.00 returned check processing fee. Payment in the form of cash, money order, or credit card must be received within 10 business days. Failure to pay your debt may result in litigation.

ACCEPTED METHOD OF PAYMENT
Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and Care Credit. Payments can be made online by going to [www.LakeEye.com](http://www.LakeEye.com) and clicking on Pay Your Bill on the top right of the page.

*We appreciate your cooperation,*

*The Physicians and Staff Lake Eye Associates*
**Release of Information**
I authorize Lake Eye Associates to release any information required to process my claim. I hereby certify that the information provided is correct and true to the best of my knowledge.

**Assignment of Insurance Benefits**
I hereby authorize payment directly to Lake Eye Associates of benefits and/or major medical benefits otherwise payable to me under the terms of my policy.

**Acknowledgement of Notice of Privacy Policy and Financial Policy**
I acknowledge that I have reviewed Lake Eye Associates Notice of Privacy Practices and Financial Policy. I understand that copies of these policies are available in all Lake Eye Associates locations, [www.lakeeye.com](http://www.lakeeye.com) and on my patient portal.

Signing below indicates that you acknowledge and authorize the notices and policies listed above;

<table>
<thead>
<tr>
<th>PRINTED NAME OF PATIENT OR REPRESENTATIVE</th>
<th>DATE</th>
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</table>

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT OR REPRESENTATIVE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Purpose of this Form:
The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you register for the Patient Portal you will be allowed the following:

- Ability to update your contact information
- Request appointments and cancellations
- Exchange results between staff and patient
- Request prescription refills
- View your medical summary, treatment history and visitation dates
- Receive reminders through your email

Online communications should never be used for life threatening emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or our office.

Reminders for Patient Portal:

- Your password is case sensitive.
- You will be receiving reminders via email. Please make security adjustments to your email to receive our emails.
- If you forget your password, you may request another by using the password reset option
- After you are finished accessing the Patient Portal be sure to logout and close your browser to reduce the risk of someone else accessing your private information.
- The portal is provided as a courtesy service for our patients. There is no service fee. If the patient abuses or misuses the Patient Portal, we reserve the right to terminate the patient’s account.
- Our hours of operation are 8:30am - 5:00pm Monday-Friday. We encourage you to use the portal at any time; Please be aware that messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- The portal will be available to the parent or guardian if patient is under 18.

How the Secure Patient Portal Works:
A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications. Secure messages and information can only be read by someone who knows the right password to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.
Protecting Your Private Health Information and Risks:
The secure message must reach the correct email address, therefore it is imperative that our practice has your correct email address on file and that you inform us of any changes. Only the correct individual, or someone authorized by that individual, must have access to the message. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly access the portal and change it.

Please initial if you are an established patient with Lake Eye Associates and have logged into the Patient Portal within the last 12 months

Patient Portal Acknowledgement and Agreement
I acknowledge that I have read and fully understand this consent form, regarding my Patient Portal. I understand the risks associated with online communications between my physician and myself.

Patient’s Secure Email Address

Printed Name of Patient or Guardian  Date of Birth

Signature of Patient or Guardian  Date

Please note, this authorization will remain in effect unless a written request to rescind authorization is submitted.
What problems are you having with your eyes? ________________________________________________________________
Date of your last eye exam: ___________________________ Referring Physician: ___________________________

OCULAR HISTORY

Do you wear glasses? □ Yes □ No If yes, how old are your current glasses? ____________
Do you wear contact lenses? □ Yes □ No If yes, hard or soft contact lenses? ____________ How many years?

Have you ever been diagnosed with any of the following? Please check all that apply.

☐ Cataracts ☐ Glaucoma ☐ Macular Hole ☐ Macular Degeneration ☐ Retinal Tear ☐ Retinal Detachment ☐ Diabetic Retinopathy
☐ Strabismus (lazy/crossed eye) ☐ Corneal Problem ☐ Dry Eye Syndrome

Have you had any eye injuries? □ Yes □ No If yes, please explain. ____________________________________________

Have you had any surgeries, laser procedures or injections to the eye? □ Yes □ No If yes, please list below.

<table>
<thead>
<tr>
<th>Eye Surgery/Procedure</th>
<th>Eye</th>
<th>Date</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

MEDICAL AND SURGICAL HISTORY

Please list any major medical conditions and injuries (diabetes, heart attack, cancer, etc.) ____________________________

Have you had any surgeries? □ Yes □ No If yes, please list below.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

FAMILY HISTORY

Please indicate if any of your immediate family (Mother, Father, Sibling, Grandparent, Child) has ever been treated for any of the following. If yes, please list the relative’s relationship to you. □ Adopted

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Cataract</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Macular Degeneration</td>
<td>Stroke</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Cancer</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Other</td>
</tr>
</tbody>
</table>

SOCIAL HISTORY

Do you smoke? □ Yes □ Former □ Never If yes, how much? ___________________________ # of years ______
Do you drink alcohol? □ Yes □ Former □ Never If yes, how much? ___________________________ # of years ______

PHYSICIAN INFORMATION

Primary Physician: ___________________________ Phone Number: ___________________ Fax Number: ___________
Address: ___________________________ City: ___________________ State: ___________
### Allergies

Do you have an allergy to latex? □ Yes □ No

Are you allergic to any medications? □ Yes □ No

If yes, please list the medication and reaction:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medications

Are you currently taking any medications? □ Yes □ No

If yes, please list all medications (include dosage and frequency):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Review of Systems

#### Constitutional

- Fatigue
- Malaise
- Chills
- Fever
- Night Sweats
- Appetite Changes
- Weight Changes

Other: __________________________

#### HEENT

- Head Injury
- Hay Fever
- Discharge
- Sinus Pain
- Decreased Hearing
- Stiffness
- Dry Mouth
- Sore Throat
- Earache
- Tinnitus
- Dentures
- Vertigo
- Difficulty Swallowing

Other: __________________________

#### Cardiovascular

- Angina
- Thrombophlebitis
- Heart Attack
- Racing Pulse
- High Cholesterol
- High BP
- Low BP
- Murmurs
- MVP

Other: __________________________

#### Respiratory

- COPD
- Shortness of breath
- Wheezing
- Cough
- Hemoptysis
- Asthma
- Tuberculosis

Other: __________________________

#### Gastrointestinal

- Diarrhea
- Constipation
- Stool Changes
- Hemorrhoids
- Indigestion
- Difficulty Swallowing
- Nausea/Vomiting

Other: __________________________

#### Genitourinary

- Blood
- Incontinence
- BPH
- Kidney Stones
- Difficult Urination
- Enlarged Prostate
- Increased Frequency
- Frequent UTI’s

Other: __________________________

#### Endocrine

- Thyroid
- Nervousness
- Diabetes (Insulin Dependent)
- Diabetes (Non – Insulin Dependent)
- Hypoglycemia
- Goiter
- Hair Loss
- Hypothyroid
- Hyperthyroid
- Heat/Cold Intolerance

Other: __________________________

#### Hematologic

- Ease of Bruising
- Excessive Bleeding
- Enlarged Lymph Nodes
- Anemia

Other: __________________________

#### Neurological

- Alzheimer’s
- Parkinson’s Disease
- Dizziness
- Paralysis
- Headaches
- Seizures
- Migraine
- Stroke
- Neuropathy
- TIA
- Tremors

Other: __________________________

#### Immunologic

- Lupus
- Rheumatoid Arthritis
- Fibromyalgia
- Multiple Sclerosis
- Crohn’s
- AIDS
- HIV+

Other: __________________________

#### Dermatological

- Rash
- Lump
- Itching
- Dryness

Other: __________________________

#### Musculoskeletal

- Arthritis
- Leg Cramps
- Swelling
- Back Pain
- Stiffness
- Joint Pain
- Muscle Aches

Other: __________________________

#### Psychiatric

- Depression
- Panic Attack
- Nervousness
- Anxiety
- Memory Loss

Other: __________________________

---

### Pharmacy Information

Preferred Pharmacy: __________________________

Phone Number: __________________________

Address: __________________________

City: __________________________ State: __________________________

Patient Signature: __________________________
Dry Eye Questionnaire

Dry Eye Disease is one of the most commonly treated ocular conditions. In order to evaluate and decide the best course of treatment for you, we ask that you complete this questionnaire.

Name:____________________________ Date of Birth:_____________ Age:_______ Date:______________

1. Questions about EYE DISCOMFORT:

   a. During a typical day in the past month, **how often** did your eyes feel discomfort?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Some4mes</th>
<th>Frequently</th>
<th>Constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ (0)</td>
<td>☐ (1)</td>
<td>☐ (2)</td>
<td>☐ (3)</td>
<td>☐ (4)</td>
</tr>
</tbody>
</table>

   b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

<table>
<thead>
<tr>
<th>Never</th>
<th>Not intense at all</th>
<th>Very intense</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ (0)</td>
<td>☐ (1)</td>
<td>☐ (2)</td>
</tr>
</tbody>
</table>

2. Questions about EYE DRYNESS:

   a. During a typical day in the past month, **how often** did your eyes feel dry?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Some4mes</th>
<th>Frequently</th>
<th>Constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ (0)</td>
<td>☐ (1)</td>
<td>☐ (2)</td>
<td>☐ (3)</td>
<td>☐ (4)</td>
</tr>
</tbody>
</table>

   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?

<table>
<thead>
<tr>
<th>Never</th>
<th>Not intense at all</th>
<th>Very intense</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ (0)</td>
<td>☐ (1)</td>
<td>☐ (2)</td>
</tr>
</tbody>
</table>

3. Questions about WATERY EYES:

   During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Some4mes</th>
<th>Frequently</th>
<th>Constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ (0)</td>
<td>☐ (1)</td>
<td>☐ (2)</td>
<td>☐ (3)</td>
<td>☐ (4)</td>
</tr>
</tbody>
</table>
4. Do you use eye drops for lubrication?  ☐ Yes ☐ No If yes, how often? ________________________________

5. Which brand of artificial tears do you use? ______________________________ Are they preservative free? ☐ Yes ☐ No

6. How long have you been treated for dry eye disease?  ☐ Never  ☐ More than one year  ☐ Less than one year

7. Do you feel your dry eye is chronic?  ☐ Yes  ☐ No Rate the severity of your dry eye on a scale of 1-10: __________

8. Have you or a family member ever been treated for an autoimmune disease?  ☐ Yes  ☐ No

9. Report any of the following allergy symptoms:  ☐ itchy eyes  ☐ red eyes  ☐ watery eyes  ☐ swollen eyes
   ☐ congestion  ☐ runny nose  ☐ itchy skin  ☐ asthma
   ☐ flakey, red skin  ☐ dark circles under eyes

10. What would you like to see improve with your dry eyes? ________________________________

Questionnaire score: __________
*A score of 7 or greater indicated order for osmolarity testing*

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OD: ________ mOSM/L