DEW	**DRY EYE: DIAGNOSTIC TEST TEMPLATE**	
RAPPORTEUR	Barbara Caffery	22th 10 2004
TEST	**DEQ questionnaire**	
TO DIAGNOSE	Test used to diagnose dry eye disease and quantify its severity.	Begley et al. 2001
VERSION of TEST	[V1] The 2002 version.	Begley et al. 2002
DESCRIPTION	The questionnaire elicits the presence of dry eye symptoms and their severity and the time of day when they are most severe.	
CONDUCT of TEST	The test is administered by the subject without help from a technician. The subject is asked to fill out the forms to the best of their ability.	
Web Video	NA	
Materials:	The questions referred to in the referenced paper (1) and are provided in the appendix.	
Diagnostic value	This version : [VI] There was not good correlation between signs and symptoms.	Begley et al. 2001, 2002
Repeatability	Intra-observer agreement. [ ] Inter-observer agreement. [ ]	
Sensitivity	**(true positives)** [ ]	
Specificity	**(100 – false positives)** [ ]	
Test problems	As in all dry eye questionnaires, the symptoms are not necessarily specific to the disease.	
Test solutions	Shorter version	
FORWARD LOOK	A shorter version with better sensitivity and specificity.	

References:

Begley C, et al., Characterization of ocular surface symptoms from optometric practices in North America. *Cornea* 2001;20(6): 610-618.

Begley C, et al., Use of the Dry Eye Questionnaire to measure symptoms of ocular irritation in patients with aqueous tear deficiency. *Cornea* 2002; 21(7): 664-670.

Appendix:

DRY EYE QUESTIONNAIRE
2002 version

Please fill in the blank or circle the answer that best describes you. Choose only one answer per question.

1. What is your age?

2. What is your gender?
1 Male
2 Female

3. Have you worn contact lenses in the past?
1 Yes
2 No

4. If you have worn contact lenses in the past, which of the following did you wear most recently?

No, Yes, Not Applicable

a. Rigid gas permeable **1 2 0**
b. Disposable (lenses replaced frequently) **1 2 0**
c. Soft daily wear (lenses replaced after 1 year or longer) **1 2 0**
d. Extended wear (lenses worn overnight) **1 2 0**

5. If you have worn contact lenses in the past, how important was each of the following issues in your decision to stop wearing contact lenses?

Not at All Important, Important, Very Important, Not applicable

a. I never got used to the lenses **1 2 3 4 5 0**
b. The lenses were uncomfortable all day **1 2 3 4 5 0**
c. The lenses were most uncomfortable
when first put in **1 2 3 4 5 0**
d. The lenses became more uncomfortable
later in the day **1 2 3 4 5 0**
e. My eyes felt dry **1 2 3 4 5 0**
f. The lenses felt scratchy and irritating **1 2 3 4 5 0**
g. My vision was not clear enough **1 2 3 4 5 0**
h. Wearing contact lenses was too much trouble **1 2 3 4 5 0**
i. Other reason (please specify below) **1 2 3 4 5 0**
_____

Patient Record
Number: _____
Date _____
Time _____
(2)

6. Questions about **EYE DISCOMFORT**:

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

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt discomfort, **how intense was this feeling of discomfort…**

b. Within the first two hours of getting up in the

morning*?*
Never Not at All Very Intense
Intense
0 1 2 3 4 5

c. At the end of the day, within two hours of going to bed*?*

Never have **it** Not at All **Intense** Very Intense

0 1 2 3 4 5

d. When your eyes felt discomfort, **how much did the discomfort bother you**?

Never have It Not at all bothered Very bothered

0 1 2 3 4 5

7. Questions about **EYE DRYNESS**:

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

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt dry, **how intense was this feeling of dryness**…

b. Within the first two hours of getting up in the morning*?*

Never have it Not at All Intense Very Intense
0 1 2 3 4 5

c. At the end of the day, within two hours of going to bed*?*
Never have it Not at All Intense Very Intense

0 1 2 3 4 5

d. When your eyes felt dry, **how much did the dryness bother you**?

Never have it Not at All bothered Extremely bothered

0 1 2 3 4 5
(3)

8. Questions about **EYE GRITTINESS AND SCRATCHINESS**:

a. During a typical day in the past week, **how often** did your eyes feel gritty and scratchy?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt grittiness and scratchiness, **how intense was this feeling of grittiness and scratchiness**…

b. Within the first two hours of getting up in the morning*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

c. At the end of the day, within two hours of going to bed*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

d. When your eyes felt gritty and scratchy, **how much did the grittiness and scratchiness bother you?**

Never have it	Not at All bothered				Extremely bothered
0	**1**	**2**	**3**	**4**	**5**

9. Questions about **EYE BURNING AND STINGING:**

a. During a typical day in the past week, **how often** did your eyes feel burning and stinging?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt burning and stinging, **how intense was this feeling burning and stinging** …

b. Within the first two hours of getting up in the morning*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

c. At the end of the day, within two hours of going to bed*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

d. When your eyes felt burning and stinging, **how much did the burning and stinging bother you**?

Never have it	Not at All bothered				Extremely bothered
0	**1**	**2**	**3**	**4**	**5**

(4)

10. Questions about **TIRED EYES:**

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

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt tired, **how intense was this feeling of tired eyes** …

b. Within the first two hours of getting up in the morning*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

c. At the end of the day, within two hours of going to bed*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

d. When your eyes felt tired, **how much did the feeling of tired eyes bother you**?

Never have it	Not at All bothered				Extremely bothered
0	**1**	**2**	**3**	**4**	**5**

11. Questions about **CHANGEABLE, BLURRY**

VISION:

a. During a typical day in the past week, **how often** did your vision change between clear and blurry or foggy?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your vision was blurry, **how noticeable was the changeable, blurry, or foggy vision** …

b. Within the first two hours of getting up in the morning*?*

Never have it	Not at All Noticeable				Very Noticeable
0	**1**	**2**	**3**	**4**	**5**

c. At the end of the day, within two hours of going to bed*?*

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

d. When your vision was blurry, **how much did the changeable, blurry or foggy vision bother you**?

Never have it	Not at All bothered				Extremely bothered
0	**1**	**2**	**3**	**4**	**5**

(5)

12. Question about **EYELID REDNESS:**
During a typical day in the past week, **how often** did your eyelid margins look red?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

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

0 Never
1 Rarely
2 Sometimes

3 Frequently
4 Constantly

14. Question about **EYE MUCUS AND CRUSTING:**
During a typical day in the past week, **how often** was mucus or crusty material in or around your eyes?
0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

15. Question about **CLOSING YOUR EYES:**
During a typical day in the past week, **how often** did your eyes bother you so much that you wanted to close them?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

16. Questions about how much different **TYPES OF AIR QUALITY BOTHER YOUR EYES:**
a. a room with **cigarette smoke or smog**?

Never have it	Not at all				Very much
0	**1**	**2**	**3**	**4**	**5**

b. a building with the **central air conditioning or heating** turned on?

Never have it	Not at all				Very much
0	**1**	**2**	**3**	**4**	**5**

c. **shopping at the mall** or **shopping in retail or fabric stores**?

Never have it	Not at all				Very much
0	**1**	**2**	**3**	**4**	**5**

17. Question about **ARTIFICIAL TEAR USE:**

During a typical day in the past week, **how often** did you use artificial tears?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

18. Question about **DRYNESS OF THE NOSE, MOUTH, OR VAGINA:**

During a typical day in the past week, **how often** did you experience dryness of the nose, mouth, or vagina?
0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly
(6)

19. During a typical day in the past week, **how often did you use a computer**?

0 Never
1 1 to 2 hours
2 3 to 6 hours
3 More than 6 hours

20. Are you currently taking any of the following medications?

	Yes	No
a. Thyroid medications	**1**	**2**
b. Blood pressure medications	**1**	**2**
c. Diabetes medications	**1**	**2**
d. Diuretics	**1**	**2**
e. Arthritis medications	**1**	**2**
f. Heart condition medications	**1**	**2**
g. Depression medications	**1**	**2**
h. Ulcer medications	**1**	**2**
i. Oral contraceptives	**1**	**2**
j. Antibiotics for acne or other skin conditions	**1**	**2**
k. Hormone replacement therapy	**1**	**2**
l. Allergy medications	**1**	**2**

21. Have you been told you have dry eye(s)?

1 Yes **2** No

22. If you use any of the following treatments for dry eye, how much help do they provide?

	No help At all				Complete Relief	Do Not Use
a. Artificial tears	**1**	**2**	**3**	**4**	**5**	**0**
b. Lubricating ointments or gels	**1**	**2**	**3**	**4**	**5**	**0**
c. Warm compresses or eyelid scrubs	**1**	**2**	**3**	**4**	**5**	**0**
d. Punctal plugs or cauterization	**1**	**2**	**3**	**4**	**5**	**0**
e. Room humidifier	**1**	**2**	**3**	**4**	**5**	**0**
f. Other (please specify below)	**1**	**2**	**3**	**4**	**5**	**0**

_____

23. Do you think you have dry eye(s)?

1 Yes **2** No

THANK YOU VERY MUCH!