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**Tearing Questionnaire**

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| # | **DURATION OF SYMPTOMS** | **Response** | |
| 1 | Which side(s) is experiencing the tearing? | [ ] Right  [ ] Left  [ ] Both | |
| 2 | How long has the tearing been bothering you? |  | |
| 3 | How often does the tearing occur overall? | [ ] Episodically  [ ] Daily / all the time | |
| 4 | How often does the tearing occur on a daily basis? | [ ] Intermittently throughout the day  [ ] Constantly throughout the day | |
| # | **TEARING QUESTIONS** | **No** | **Yes** |
| 5 | Have you had prior surgery to address the tearing? | □ | □ What/when |
| 6 | Have you used any medications / dry eye drops to treat the tearing? | □ | □ Name of medication(s) |
| 7 | Do you perform any warm or cool compresses | □ | □ |
| 8 | Have you ever used punctal plugs | □ | □ |
| 9 | Do you have a history of: ocular cicatricial pemphigoid, Stevens-Johnson Syndrome, or burns/chemical injuries to the eye? |  |  |
| 10 | Do you have a history of any trauma to the nose/face | □ | □ |
| 11 | Do you have any history of sinus issues? | □ | □ |
| 12 | Do you have any history of cancer of the nose/sinus? | □ | □ |
| 13 | Do you have history of radiation treatment to the face | □ | □ |
| 14 | Do you have history of receiving chemotherapy? | □ | □ |