Patient ID: _____ Date: _____

Canadian Dry Eye Assessment (CDEA)

Please complete this questionnaire. It will help to grade the severity of your Dry Eye symptoms.

Have you experienced any of the following symptoms?	0 None of the time	1 Some of the time	2 Half of the time	3 Most of the time	4 All of the time	Scoring 0-4
1. Sensitivity to light, during the last week						
2. Gritty or scratchy sensation, during the last week						
3. Burning or stinging, during the last week						
4. Blurred/unclear vision, during the last week						
5. Vision that fluctuates with blinking, during the last week						
6. Vision that improves with artificial tears, during the last week						
7. Tearing/watering, during the last week						
8. Pain/burning during the night or upon awakening in the morning, during the last week						
Have you experienced eye irritation while performing any of these activities?						
9. Reading or driving a car for long periods, during the last week						
10. Watching TV/working on a computer for an extended period, during the last week						
Have your eyes felt uncomfortable in any of the following situations?						
11. During wind/air draft exposure, during the last week						
12. In places with low humidity (heated/cooled places, i.e. planes), during the last week						
						TOTAL SCORE

How much do your eyes bother you? Please check box from 1 – 10

TOTAL SCORE: Add Score from Questions 1 - 12

1 Not at all	2	3	4	5 Moderately	6	7	8	9	10 Extremely & Constantly
○	○	○	○	○	○	○	○	○	○

Please answer the following questions:

A. What brand of artificial tears are you using?

B. How often do you use artificial tears? Times per day? Days per week?

C. Are your symptoms better, worse or the same as your last visit? ○ Better ○ Worse ○ Same