For office use only:
Total score:_____

Advanced Eye Care & Surgery Center

Eye Allergy Patient Impact Questionnaire

Name: _____ Date: _____
Date of birth: _____ MR#: _____

The following questions refer to seasonal eye allergy symptoms you may have or have had. Please answer each question checking the box which best describes your situation.

Occurrence of eye allergy symptoms

Please indicate over the **past month**, **how often** did you suffer from each of the eye allergy symptoms below as they relate to either or both of your eyes:

Symptoms	Never	Sometimes	Often	Constant
Swollen/puffy eyes or eyelids				
Watery eyes				
Red eyes				
Itchy/burning eyes				
Dry eyes				

Please rate the **severity** of the symptoms you suffer from the following eye allergy symptoms in the **past month**:

Tolerable= not perfect but not uncomfortable
Uncomfortable= irritating but does not interfere with my daily tasks
Bothersome= irritation and interferes with my daily tasks
Intolerable= unable to perform my daily tasks

Symptoms	No problems	Tolerable	Uncomfortable	Bothersome	Intolerable
Swollen/puffy eyes or eyelids					
Watery eyes					
Red eyes					
Itchy/burning eyes					
Dry eyes					