

Dry Eye Evaluation Form

For completion by the veteran's eye doctor. Designed to support diagnosis, severity documentation, treatment history, and diagnosis analysis.

Use: The veteran may complete demographic and symptom-history sections before the visit (Sections 1-4). The eye doctor should complete the examination, diagnosis, treatment, and provider attestation sections (Sections 5-8). This is a clinical documentation tool and does not guarantee a VA disability outcome.

1. Patient and visit information

Patient name	_____	Date of birth	_____
Date of exam	_____	Claimed condition	Dry eye / ocular surface disease
Eye doctor	_____	Clinic	_____
Phone	_____	Email / fax	_____

2. History and possible service-related exposures

Symptom onset	Approximate date or time period: _____
Course since onset	☐ Constant ☐ Intermittent ☐ Progressive ☐ Stable with treatment ☐ Waxing and waning
Potential in-service exposures or triggers	☐ Burn pits ☐ Desert dust / sand ☐ Wind exposure ☐ Smoke / particulates ☐ Chemical irritants ☐ CPAP use ☐ Prolonged screen or computer tasks ☐ Medications ☐ Other: _____
Relevant non-service factors	☐ Autoimmune disease ☐ Contact lens wear ☐ LASIK / ocular surgery ☐ Antihistamine use ☐ Isotretinoin ☐ Menopause / hormonal factors ☐ Diabetes ☐ Thyroid disease ☐ None known ☐ Other: _____
Additional Comments:	

3. Symptom severity

Provider instruction: Check the symptoms present and, when possible, estimate frequency or severity based on the history you find most clinically accurate.

Symptom	Present	Severity	Frequency / comments
Burning or stinging	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Foreign body sensation / grittiness	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Redness	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Reflex tearing / watering	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Fluctuating or blurred vision	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Light sensitivity	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Mucous / stringy discharge	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Eye fatigue with reading or screen use	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Pain or soreness	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____
Symptoms worse in wind, smoke, HVAC, or low humidity	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe	_____

4. Functional impact

Reading, computer work, forms, or detailed near tasks	☐ None ☐ Mild ☐ Moderate ☐ Severe Comments: _____
Driving, especially night driving	☐ None ☐ Mild ☐ Moderate ☐ Severe Comments: _____
Work duties or productivity	☐ None ☐ Mild ☐ Moderate ☐ Severe Comments: _____
Need for breaks, drops, or environmental modification	☐ None ☐ Occasional ☐ Frequent ☐ Daily / ongoing

5. Objective examination findings

Complete as clinically appropriate: Document the findings you consider relevant. Not every line must be used in every case.

NOTE: You are being asked to provide objective clinical data regarding the veteran's ocular condition(s). Ocular Disability Consultants will evaluate your findings as well as the veteran's service records, VA health records, and subjective complaints to provide an opinion concerning eligibility for veteran's benefits.

Visual acuity (best corrected)	OD _____ OS _____
External / lids / lashes	_____
Conjunctiva / injection	_____
Cornea / ocular surface staining	Type / grading / location: _____
Tear film and breakup time	TBUT OD _____ sec OS _____ sec Tear meniscus: _____
Schirmer or tear production testing	Schirmer/ZoneQuick OD _____ mm OS _____ mm With anesthesia? YES NO
Meibomian gland dysfunction	☐ None ☐ Mild ☐ Moderate ☐ Severe Notes: _____
Other pertinent testing	Osmolarity / InflammaDry / meibography / lagophthalmos / exposure findings: _____

6. Diagnosis and severity assessment

Current diagnosis	☐ Dry eye disease ☐ Keratoconjunctivitis sicca ☐ Ocular surface disease ☐ Allergic conjunctivitis ☐ Blepharitis / MGD ☐ Other: _____
Laterality	☐ Right ☐ Left ☐ Bilateral
Clinical subtype	☐ Aqueous deficient ☐ Evaporative ☐ Mixed mechanism ☐ Exposure-related ☐ Other: _____
Overall severity	☐ Mild ☐ Moderate ☐ Severe
Prognosis / expected need for treatment	

7. Treatment history and response

Treatment or recommendation	Attempted	Current	Response / notes
Artificial tears / lubricating drops	☐ Yes ☐ No	☐ Yes ☐ No	_____
Lubricating ointment / gel	☐ Yes ☐ No	☐ Yes ☐ No	_____
Warm compresses / lid hygiene	☐ Yes ☐ No	☐ Yes ☐ No	_____
Prescription anti-inflammatory drop	☐ Yes ☐ No	☐ Yes ☐ No	_____
Oral doxycycline / omega-3 / support	☐ Yes ☐ No	☐ Yes ☐ No	_____
Punctal plugs or cautery	☐ Yes ☐ No	☐ Yes ☐ No	_____
Allergy-directed therapy	☐ Yes ☐ No	☐ Yes ☐ No	_____
Environmental modification / work changes	☐ Yes ☐ No	☐ Yes ☐ No	_____

8. Standardized Symptom Validation

OSDI, SPEED, DEQ-5 or other validated symptom score	Type: _____ Score: _____
	Date: _____

9. Provider summary and attestation

Clinical Notes	Summarize the diagnosis, severity, important findings, and treatment course: _____ _____ _____ _____
Is the condition currently active and symptomatic?	☐ Yes ☐ No
What ICD-10 codes are appropriate for this patient's condition(s)?	☐ Dry eye syndrome, right lacrimal gland — H04.121 ☐ Dry eye syndrome, left lacrimal gland — H04.122 ☐ Dry eye syndrome, bilateral lacrimal glands — H04.123 ☐ Dry eye syndrome, unspecified lacrimal gland — H04.129 ☐ Keratoconjunctivitis sicca, not specified as Sjögren's, right eye — H16.221 ☐ Keratoconjunctivitis sicca, not specified as Sjögren's, left eye — H16.222 ☐ Keratoconjunctivitis sicca, not specified as Sjögren's, bilateral — H16.223 ☐ Keratoconjunctivitis sicca, not specified as Sjögren's, unspecified eye — H16.229 ☐ Exposure keratoconjunctivitis, bilateral — H16.213 ☐ Sjögren's-related dry eye, bilateral — M35.01 ☐ Meibomian gland dysfunction, right eye, upper and lower eyelids — H02.88A ☐ Meibomian gland dysfunction, left eye, upper and lower eyelids — H02.88B ☐ Other ocular diagnosis: _____ ICD-10-CM: _____
Provider attestation	I certify that I personally evaluated or reviewed the above patient as documented, and the information entered on this form accurately reflects my clinical findings and medical judgment. Provider signature: _____ Date: _____ Printed name: _____ Credential (OD/MD): _____ Clinic name: _____ Address: _____ License state / number: _____ NPI: _____