Patient Eye Drop Assessment

Patient sticker

Date of visit:_____

What glaucoma treatment are you using?

Name	Which eye?	How often?	Still using? Y/N	If no why did you stop?

Who puts in your drops?

You	Family member	Carer	Community nurse	Other

How often do you miss your drops?

Very often	Often	Sometimes	Rarely	Never

Patient Eye Drop Assessment

Why do you miss your drops?

	Very often	Often	Sometimes	Hardly ever	Never
Difficulty physically putting drops in					
Forget					
Run out of drops					
Forget to take drops with me when out					
Too many drops to put in at once					
Uncertain which drops to put in					
Uncertain how much drops to put in					
Other (please say what below)					

Patient Eye Drop Assessment

What makes it physically difficult to put drops in properly?

	Very often	Often	Sometimes	Hardly ever	Never
Difficulty opening the bottle					
Difficulty squeezing the bottle					
Difficulty keeping eyes open					
Difficulty keeping hand still					
Difficulty getting drops into eye/missing the eye					
Unpleasant taste					
Touch nozzle on eye					
Touch nozzle on something else					
Other (please say what below)					

Patient Eye Drop Assessment

Are you experiencing any possible side effects with your drops?

☐ red eyes

☐ painful and uncomfortable eyes

☐ İtchy eyes

☐ headaches

☐ shortness of breath or wheezing

☐ other (please say what): _____

Do you have any other conditions which might affect using drops:

☐ asthma/ COPD/breathing problems

☐ use inhaler for any reason

☐slow heart rate

☐ other (please say what)

☐ arthritis or muscular problem

☐ dementia

☐ learning disability

Patient Eye Drop Assessment

Do you have any questions about your eye condition or treatment that you would like the doctor or nurse to answer? Please specify