

Ocular Surface Disease Index[®] (OSDI[®])²

Ask your patient the following 12 questions, and circle the number in the box that best represents each answer. Then, fill in boxes A, B, C, D, and E according to the instructions beside each.

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING DURING THE LAST WEEK:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light?	4	3	2	1	0
2. Eyes that feel gritty?	4	3	2	1	0
3. Painful or sore eyes?	4	3	2	1	0
4. Blurred vision?	4	3	2	1	0
5. Poor vision?	4	3	2	1	0

Subtotal score for answers 1 to 5 **(A)**

HAVE PROBLEMS WITH YOUR EYES LIMITED YOU IN PERFORMING ANY OF THE FOLLOWING DURING THE LAST WEEK:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
6. Reading?	4	3	2	1	0	N/A
7. Driving at night?	4	3	2	1	0	N/A
8. Working with a computer or bank machine (ATM)?	4	3	2	1	0	N/A
9. Watching TV?	4	3	2	1	0	N/A

Subtotal score for answers 6 to 9 **(B)**

HAVE YOUR EYES FELT UNCOMFORTABLE IN ANY OF THE FOLLOWING SITUATIONS DURING THE LAST WEEK:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
10. Windy conditions?	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12. Areas that are air conditioned?	4	3	2	1	0	N/A

Subtotal score for answers 10 to 12 **(C)**

ADD SUBTOTALS A, B, AND C TO OBTAIN D
(D = SUM OF SCORES FOR ALL QUESTIONS ANSWERED) **(D)**

TOTAL NUMBER OF QUESTIONS ANSWERED
(DO NOT INCLUDE QUESTIONS ANSWERED N/A) **(E)**

Please turn over the questionnaire to calculate the patient's final OSDI[®] score.