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A VISUAL AFFAIR
DOCTORS OF OPTOMETRY

Ocular Surface Disease Index© - (OSDI) QUESTIONNAIRE

Please answer all questions by marking the number in the box that best represents your answer to each question. Your responses help us better understand any dry eye symptoms and provide the best possible care.

Have you experienced any of the following during the last week?

	4 Always	3 Most	2 Half	1 Some	0 None
Sensitive to light	☐	☐	☐	☐	☐
Gritty eyes	☐	☐	☐	☐	☐
Painful/sore eyes	☐	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐	☐
Poor vision	☐	☐	☐	☐	☐

During the past week, have your eyes limited your ability to:

	4 Always	3 Most	2 Half	1 Some	0 None	N/A
Reading?	☐	☐	☐	☐	☐	☐
Driving at night?	☐	☐	☐	☐	☐	☐
Working on a computer?	☐	☐	☐	☐	☐	☐
Watching TV?	☐	☐	☐	☐	☐	☐

During the past week, have your eyes felt uncomfortable in any of these situations?

	4 Always	3 Most	2 Half	1 Some	0 None	N/A
Windy conditions	☐	☐	☐	☐	☐	☐
Low humidity	☐	☐	☐	☐	☐	☐
Air-conditioned areas	☐	☐	☐	☐	☐	☐

SUM of scores for all questions answered: _____

Total number of questions answered (do not include N/A): _____