Patient Name: _____ ☐ **RIGHT EYE**

Date: _____ ☐ **LEFT EYE**

DRY EYE QUESTIONNAIRE - PART 1: SPEED **PAGE 1 OF 2**

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question. If you need to make a change, cross out the original answer with a single line and write your initials and the date next to the change.

1. Report the type of <u>SYMPTOMS</u> you experience and when they occur:

SYMPTOMS	AT THIS VISIT		WITHIN PAST 72 HRS		WITHIN PAST 3 MONTHS	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the <u>FREQUENCY</u> of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the <u>SEVERITY</u> of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?**

_____

5. Has the treatment improved your overall dry eye symptoms? ☐ YES ☐ NO

If yes, check the closest percentage:

☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

6. Are you able to perform any task(s) better or for longer as a result of treatment? ☐ YES ☐ NO

If yes, list the task(s):

_____

Patient Name: _____ ☐ **RIGHT EYE**

Date: _____ ☐ **LEFT EYE**

DRY EYE QUESTIONNAIRE - PART 2: OSDI **PAGE 2 OF 2**

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question. If you need to make a change, cross out the original answer with a single line and write your initials and the date next to the change.

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

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

Have problems with your eyes limited you in performing any of the following *during the last week*?
If you did not perform the activity listed, select "N/A" (Not Applicable).

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

Have your eyes felt uncomfortable in any of the following situations *during the last week*?
If you have not experienced the situation listed, select "N/A" (Not Applicable).

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