CONCOURSE OPTOMETRY

OSDI Questionnaire

Patient Name _____ Exam Date _____

DURING THE PAST WEEK:

Have you experienced any of the following?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
Eyes that are sensitive to light?	4	3	2	1	0
Eyes that feel gritty?	4	3	2	1	0
Painful or sore eyes?	4	3	2	1	0
Blurred Vision?	4	3	2	1	0
Poor vision?	4	3	2	1	0

Subtotal Score _____

Have problems with your eyes limited you in performing any of the following?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
Reading?	4	3	2	1	0	N/A
Driving at night?	4	3	2	1	0	N/A
Working with a computer or bank machine (ATM)?	4	3	2	1	0	N/A
Watching TV?	4	3	2	1	0	N/A

Subtotal Score _____

Have your eyes felt uncomfortable in any of the following situations?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
Windy conditions?	4	3	2	1	0	N/A
Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
Areas that are air conditioned?	4	3	2	1	0	N/A

Subtotal Score _____

NUMBER OF QUESTIONS ANSWERED_____ TOTAL SCORE _____

(not including questions answered N/A)