0 None of the time
1 Some of the time
2 Half of the time
3 Most of the time
4 All of the time

Eye Health Questionnaire

OSDI Questions and Scoring

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

Domain 1: Ocular Symptoms	4	3	2	1	0
1. Eyes that are sensitive to light?	☐	☐	☐	☐	☐
2. Eyes that feel gritty?	☐	☐	☐	☐	☐
3. Painful or sore eyes?	☐	☐	☐	☐	☐
4. Blurred vision?	☐	☐	☐	☐	☐
5. Poor vision?	☐	☐	☐	☐	☐

Subtotal for answers 1 to 5 **(A)** **Score:**

Have problems with your eyes limited you in performing any of the following during the last week?

Domain 2: Vision-Related Function	4	3	2	1	0	N/A
6. Reading?	☐	☐	☐	☐	☐	☐
7. Driving at night?	☐	☐	☐	☐	☐	☐
8. Working with a computer or bank machine (ATM)?	☐	☐	☐	☐	☐	☐
9. Watching TV?	☐	☐	☐	☐	☐	☐

Subtotal for answers 6 to 9 **(B)** **Score:**

Have your eyes felt uncomfortable in any of the following situations during the last week?

Domain 3: Environmental Triggers	4	3	2	1	0	N/A
10. Windy conditions?	☐	☐	☐	☐	☐	☐
11. Places or areas with low humidity (very dry)?	☐	☐	☐	☐	☐	☐
12. Areas that are air conditioned?	☐	☐	☐	☐	☐	☐

Subtotal for answers 10 to 12 **(C)** **Score:**

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OSDI Score		
0-12 Normal	Add subtotals A + B + C to obtain D	(D)
13-22 Mild Dry Eye	Total # of questions answered (do not include questions answered N/A)	(E)
23-32 Moderate Dry Eye		
33-100 Severe Dry Eye	**OSDI Score:**	

OSDI Score = [(sum of scores D) x 25)] / number of questions answered E

OSDI instrument introduced in 1997 by Outcomes Research Group; Allergan, Inc; Irvine, CA.

PATIENT HISTORY

SEX: ☐ M ☐ F **Date of Last Eye Exam:** _____

Do You Wear Glasses? ☐ YES ☐ NO If so, How Old? (glasses) _____ **months**

Do You Wear Contact Lenses? ☐ YES ☐ NO _____ **years**

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐ YES ☐ NO

Do you get migraine headaches? ☐ YES ☐ NO

Have you ever had a blood transfusion? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

If YES, how frequent? _____

Are you a Tobacco smoker? ☐ YES ☐ NO

If YES, what is the frequency? _____ How many years? _____

Do you currently have any problems in the following areas? If YES, please provide additional information below.	YES	NO
General / Constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)	☐	☐
Ears, Nose, Throat (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)	☐	☐
Cardiovascular (high BP, racing pulse, etc.)	☐	☐
Respiratory (congestion, wheezing, short of breath, etc.)	☐	☐
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)	☐	☐
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, yellow jaundice, etc.)	☐	☐
Females Are you pregnant? Nursing?	☐	☐
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)	☐	☐
Skin (pimples, warts, growths, rash, etc.)	☐	☐
Neurological (numbness, headache, seizures, paralysis, etc.)	☐	☐
Psychiatric (anxiety, depression, insomnia)	☐	☐
Endocrine (diabetes, hypothyroid, etc.)	☐	☐
Blood / Lymph (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)	☐	☐
Allergic / Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)	☐	☐

Details:

Patient History Continued on back

Physician's Signature _____ **Today's Date** _____ Patient Name: _____ (Last Name, First Name)

PATIENT HISTORY continued...

Eyes	Yes	No		Yes	No		Yes	No
Poor Vision	☐	☐	Double Vision	☐	☐	Blurred Vision	☐	☐
Poor Night Vision	☐	☐	Halos Around Lights	☐	☐	Flashes of Lights	☐	☐
Floating Spots	☐	☐	Color Blindness	☐	☐	Difficulty Driving	☐	☐
Red Eyes	☐	☐	Itching	☐	☐	Eye Pain	☐	☐
Discharge or Matter	☐	☐	Burning	☐	☐	Red Swollen Lids	☐	☐
Gritty Sensation	☐	☐	Sensitivity to Light	☐	☐			

Details:

List any medications you currently take (Rx and over-the-counter) (☐ None) (☐ list of medications on separate page)

	Med Name	Directions on Use
1		
2		
3		
4		
5		
6		

Do you have allergies to any medications? ☐ YES ☐ NO
If YES, list the medications:

List all major injuries (concussion, etc.):

List all conditions/diseases you had or currently have:

☐ Asthma ☐ Diabetes ☐ Stroke
☐ Cataract ☐ Hypertension ☐ Cancer
☐ Glaucoma ☐ Heart Disease ☐ Thyroid Disease
☐ Macular Degeneration ☐ COPD ☐ Arthritis

☐ Other conditions/diseases:

List any surgeries you have had (cataract, appendectomy):

	Surgery	Surgery Date		Surgery	Surgery Date
1			3		
2			4		

Other Procedures:

FAMILY HISTORY

Has any member of your family had these conditions/diseases? ☐ YES ☐ NO ☐ UNKNOWN

Check all that apply	Mother	Father	Grand Mother	Grand Father	Sister	Brother
Blindness	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐

List other heritable conditions/diseases along with the family member who has it: