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 much? _____

Do you smoke? ☐ YES ☐ NO

If YES, how much? _____ How many years? _____

| Do you currently have any problems in the following areas? If YES, please provide additional information. | 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**

Tech: _____

First Name: _____

Physician's Signature _____ Date _____

Last 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 provided on separate page )

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

List all major injuries (concussion, etc.):

List all major illnesses you have had:

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

☐ Other illnesses:

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

## FAMILY HISTORY

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

Who? (check all that apply) ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling

Which Diseases? (check all that apply)

☐ Blindness ☐ Diabetes ☐ Stroke ☐ Other heritable disease:
☐ Cataract ☐ Hypertension ☐ Cancer
☐ Glaucoma ☐ Heart Disease ☐ Thyroid Disease
☐ Macular Degeneration ☐ Arthritis