

## Dry Eye Assessment

Name \_\_\_\_\_

Date \_\_\_\_\_

Please circle the number in the box that best represents each answer.

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

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

Subtotal score for answers 1 – 5 \_\_\_\_\_

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

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

Subtotal score for answers 6 - 9 \_\_\_\_\_

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

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

Subtotal score for answers 10 - 12 \_\_\_\_\_

SUM OF SCORES FOR ALL QUESTIONS ANSWERED \_\_\_\_\_

TOTAL NUMBER OF QUESTIONS ANSWERED \_\_\_\_\_