Dry Eye Survey

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING DURING THE LAST WEEK:

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

Subtotal score for answers 1 to 5: (A)

HAVE YOU PROBLEMS WITH YOUR EYES LIMITED YOU IN PERFORMING ANY OF THE FOLLOWING DURING THE LAST WEEK:

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

Subtotal score for answers 6 to 9: (B)

HAVE YOUR EYES FELT UNCOMFORTABLE IN ANY OF THE FOLLOWING SITUATIONS DURING THE LAST WEEK:

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

Subtotal score for answers 10 to 12: (C)

Thank you!