**Please answer the following questions by checking the box that best represents your answer.**

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | All of the time **4** |  Most of the time **3** | Half of the time **2** | Some of the time**1** | None of the time **0** |
| 1 | Eyes that are sensitive to light? **(opsens)** |  |  |  |  |  |
| 2 | Eyes that feel gritty? ***(*opgrit)** |  |  |  |  |  |
| 3 | Painful or sore eyes? **(opsore)** |  |  |  |  |  |
| 4 | Blurred vision? **(opblur)** |  |  |  |  |  |
| 5 | Poor vision? **(oppoor)** |  |  |  |  |  |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | All of the time **4** |  Most of the time **3**  | Half of the time **2** | Some of the time **1** | None of the time **0** | Not applicable **99** |
| 6 | Reading? **(opreading)** |  |  |  |  |  |  |
| 7 | Driving at night?  **(opdrive)** |  |  |  |  |  |  |
| 8 | Working with a computer or bank machine (ATM)? **(opatm)** |  |  |  |  |  |  |
| 9 | Watching TV? **(optv)** |  |  |  |  |  |  |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | All of the time**4** |  Most of the time **3** | Half of the time **2** | Some of the time **1** | None of the time**0** | Not applicable**99** |
| 10 | Windy conditions?  **(opwind)** |  |  |  |  |  |  |
| 11 | Places or areas with low humidity (very dry)? **(ophumid)** |  |  |  |  |  |  |
| 12 | Areas that are air conditioned? **(opairc)** |  |  |  |  |  |  |

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**Score: osdi\_score**