Name:_____ Date:_____/_____/_____ Sex: M F DOB___/___/____

1. During a typical day in the past month, how often did your eyes feel discomfort, dry, or watery?
   ☐NEVER (0) ☐RARELY (1) ☐SOMETIMES (2) ☐FREQUENTLY (3) ☐CONSTANTLY (4)
2. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day?

	NOT AT ALL INTENSE			VERY INTENSE
☐ NEVER HAVE IT (0)	1	2	3	4

3. Report the type of SYMPTOMS you experience and when they occur (1=YES or 0=NO):

Dryness/Grittiness/Scratchiness: Now? _____ Within past 72 hr? _____ Within past 3 mo? _____

Soreness or Irritation: Now? _____ Within past 72 hr? _____ Within past 3 mo? _____

Burning or Watering: Now? _____ Within past 72 hr? _____ Within past 3 mo? _____

Eye Fatigue/Tiredness (End of Day): Now? _____ Within past 72 hr? _____ Within past 3 mo? _____

4. Report the FREQUENCY of your symptoms: (0 = NEVER, 1 = SOMETIMES, 2 = OFTEN, 3 = CONSTANT)

Dryness/Grittiness/Scratchiness:_____ Soreness or Irritation: _____

Burning or Watering: _____ Eye Fatigue/Tired: _____

5. Report the SEVERITY of symptoms: (0=None, 1=Tolerable, 2=Uncomfortable, 3=Bothersome,4=Intolerable)

Dryness/Grittiness/Scratchiness:_____ Soreness or Irritation: _____

Burning or Watering: _____ Eye Fatigue/Tired: _____

6. Do you use eyedrops for lubrication? ☐YES=1 ☐NO=0 If yes, how often? _____

Total "Ocular Surface Disease Score" =_____ 0-5=Mild, 6-9=Moderate, 10-14=Severe, 15 or higher=Extreme! ☹