

Please circle the number that best applies to your dry eye symptoms.

If a question does not apply to you, please skip to the next question for questions #1-5 or circle “N/A” for questions #6-12.

	ALL THE TIME	MOST OF THE TIME	HALF OF THE TIME	SOME OF THE TIME	NONE OF THE TIME	
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING <i>DURING THE LAST WEEK?</i>						
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	
HAVE PROBLEMS WITH YOUR EYES LIMITED YOU IN PERFORMING ANY OF THE FOLLOWING <i>DURING THE LAST WEEK?</i>						
6. Reading?	4	3	2	1	0	N/A
7. Driving at night?	4	3	2	1	0	N/A
8. Working at a computer or bank machine (ATM)?	4	3	2	1	0	N/A
9. Watching TV?	4	3	2	1	0	N/A
HAVE YOUR EYES FELT UNCOMFORTABLE IN ANY OF THE FOLLOWING SITUATIONS <i>DURING THE LAST WEEK?</i>						
10. Windy conditions?	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12. Areas that are air conditioned?	4	3	2	1	0	N/A

- A** ADD ALL SCORES FROM ANSWERS TO QUESTIONS 1 - 12 **A**
- B** MULTIPLY SUM OF SCORES (BOX A) X 25 **B**
- C** TOTAL NUMBER OF QUESTIONS ANSWERED
(DO NOT INCLUDE QUESTIONS ANSWERED N/A) **C**
- D** DIVIDE BOX B BY BOX C **D**

If the number in **Box D** is greater than **13**, you may benefit from an eye examination in the University Eye Center, Dry Eye Clinic.

Please call 510-642-2020 and ask to be scheduled in the Dry Eye Clinic.