

Ocular Surface Disease Index 6: OSDI 6*



Name:			Date of birth: ____ / ____ / ____
Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other

Please answer the following questions by circling the numbers in the boxes:

	Constantly	Mostly	Often	Sometimes	Never
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Have you experienced any of the following during a typical day in the last month?

1. Eyes that are sensitive to light	4	3	2	1	0
2. Vision blurring between blinks (with your refractive correction)	4	3	2	1	0

Symptoms and Visual Disturbance Subscale

Have problems with your eyes that limited you in performing any of the following during a typical day in the last month?

3. Driving or being driven at night	4	3	2	1	0
4. Watching TV (or similar task)	4	3	2	1	0

Visual Function / Task Subscale

Have your eyes felt uncomfortable in any of the following situations during a typical day in the last month?

5. Windy conditions	4	3	2	1	0
6. Places or areas with low humidity	4	3	2	1	0

Environmental Subscale

Sum of all questions: _____

Normal (0-3 points)
Mild to Moderate Dry Eye Disease (4-8 points)
Severe Dry Eye Disease (>8)

Notes:

Attending Clinician: _____

Date: _____