



**DRY, ITCHING,
BURNING**



**SENSITIVITY TO
LIGHT/BLURRY VISION**



WATERING EYES



**PROBLEMS WEARING
CONTACT LENSES**

DON'T DENY YOUR DRY EYES

➔ **Take the questionnaire eye doctors use to help assess Chronic Dry Eye (CDE)—the Ocular Surface Disease Index (OSDI®)—on the other side and show the results to your eye doctor.**

My **DRY EYES** 

It may surprise you that if you are experiencing any of these symptoms, you may have CDE disease.

CDE disease can also affect daily activities that involve your eyes such as:

- » Reading
- » Driving at night
- » Watching TV
- » Working on the computer
- » Wearing contact lenses

Over time, CDE disease can have potential consequences for your eyes—damage to the front surface to the eye, increased risk of eye infection, and effects on your vision.

Could You Have Chronic Dry Eye Disease?

Follow these steps to give your eye doctor a head start in evaluating if you have Chronic Dry Eye disease.

1. Answer the questions to the right and fill in boxes **A**, **B**, and **C**

2. Add boxes **A**, **B**, and **C** and enter total here (**D**)

3. Insert total number of questions answered (out of 12) (**E**)

4. Find **D** on the horizontal axis of the chart

5. Find **E** on the vertical axis of the chart

6. Where **D** and **E** meet is where your OSDI® score falls on the dry eye severity scale

$$\text{OSDI}^{\circledR} = \frac{(\text{sum of scores}) \times 25}{(\# \text{ of questions answered})}$$

Show the results to your eye doctor today.

mydryeyes.com

Download on the App Store
Download the Dry Eye OSDI® app to your iPhone

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APC28KE15

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

A Physical Symptoms

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
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

PLEASE CIRCLE YOUR ANSWERS

Subtotal score for answers 1 to 5

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

B Daily Activities

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

PLEASE CIRCLE YOUR ANSWERS

Subtotal score for answers 6 to 9

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

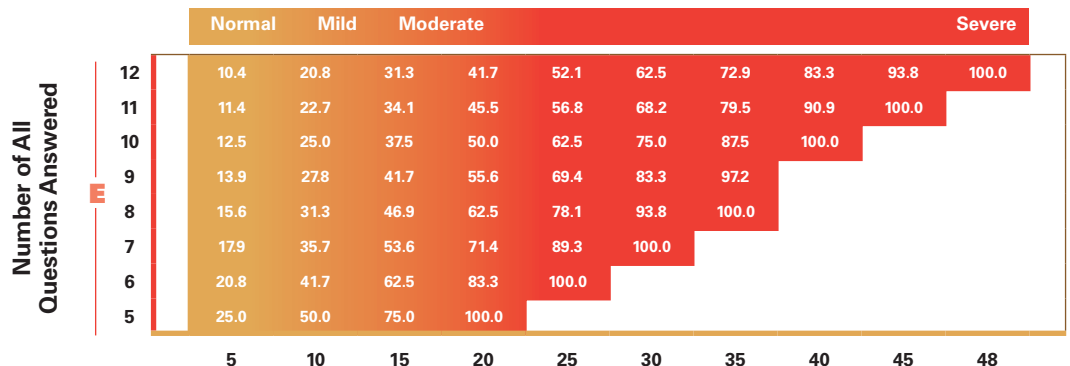
C Environmental Factors

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
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

PLEASE CIRCLE YOUR ANSWERS

Subtotal score for answers 10 to 12

OSDI® CHART



Sum of Scores for All Questions Answered

D