Please circle your answer to the following questions:

Have you experienced any of the following during the last week, and to what severity?

Eyes are sensitive to light:

None Sometimes Half of the time Most of the time All of the time

Eyes feel gritty:

None Sometimes Half of the time Most of the time All of the time

Painful or sore eyes:

None Sometimes Half of the time Most of the time All of the time

Blurred Vision:

None Sometimes Half of the time Most of the time All of the time

Poor Vision:

None Sometimes Half of the time Most of the time All of the time

Have problems with your eyes limited you in performing any of these activities in the last week?

Reading: None Sometimes Half of the time Most of the time Always

Driving: None Sometimes Half of the time Most of the time Always

Computer or ATM: None Sometimes Half of the time Most of the time Always

Watching TV: None Sometimes Half of the time Most of the time Always

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

Windy Conditions: None Sometimes Half of the time Most of the time Always

Very Dry Places: None Sometimes Half of the time Most of the time Always

Air Conditioned Spaces: None Sometimes Half of the time Most of the time Always

Score(Calculated by Technician)_____