1. Run-In gelcaps compliance

**Ineligible, STOP!**

⬜ Check here if no bottles returned

1.A. Does the number of returned pills indicate compliance with the study protocol?” **(cmcmpl)**

( )0 No , **ineligible, STOP!**

( )1Yes

0

**(cmdrugr)**

\_\_\_\_\_ Number of returned pills

**(cmret)**

1. Ask the patient if they have developed any of the following conditions since the DREAM Screening Visit:

No Yes

**Patient is ineligible.**

Record on the Adverse Event log.

a. Atrial Fibrillation **(aeatrial)** 0 1

b. Hemophilia, thrombocytopenia or other bleeding issues

(aehemop) 0 1

c. Liver disease **(aeliver)** 0 1

d. Uncontrolled ocular or systemic disease **(mhunoc)** 0 1

e. Started taking an anti-coagulant such as 0 1

Warfarin, Coumadin, Jantoven, Marevan, Uniwarfin,

Heparin or Warf? **(cmantc)**

2.A. “How many years did you smoke

cigarettes on a daily basis?” **(susmnum)**

\_\_ \_\_

2.B. “Do you currently smoke cigarettes?” **(susmcur)**

( )1 Yes

( )2 No, quit less than one year ago

( )3 No, quit more than one year ago

0

1. “Have you ever smoked cigarettes on a daily basis?” **(sucigs)**

( )1 Yes

( )0 No

**Complete the Concomitant Medication Log for every medication taken.**

4. Is the patient currently taking any prescription or over-the counter (OTC) medication (do not include OTC vitamins, minerals, and dietary supplements)? **(cmotcm)**

( )1 Yes

( )0 No

5. Has the patient used antihistamine eye drops since the screening visit? **(cmantnew)**

**Record on the Concomitant Medication Log.**

( )1 Yes

( )0 No

6.. Has the patient taken omega‑3, EPA, or DHA within the last 30 days? **(cmomega)**

**Complete the Dietary Supplement Form.**

( )1 Yes

( )0 No

7.. Is the patient currently taking Alpha- Linolenic Acid (ALA) or Vitamin E? **(cmala)**

**Complete the Dietary Supplement Form.**

( )1 Yes

( )0 No

8. “Since your last visit, have you made any changes in your dry eye treatment?” **(opdryeye)**

**Complete a Dry Eye Treatment History Form.**

( )1 Yes

( )0 No

9. Since your last visit, have you had any new symptoms, injuries, illness or side effects or worsening of pre-existing conditions?” **(opworse)**

**Record on the Adverse Event Log.**

( )1 Yes

( )0 No

10. “Since your last visit, have you had any health event which required major medical intervention or hospitalization?” **(aevst)**

**Record on the Adverse Event Log.**

( )1 Yes

( )0 No

11a. Print last name of staff completing this form: **(qclname)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Certification #: \_\_ \_\_ \_\_ \_\_ **(qcconcert)**

12. Date this form completed **(qccompdtc)**

\_\_\_\_ \_\_\_\_ / \_\_\_\_ \_\_\_\_ / 201 \_\_

Month Day Year

Archived question

5. Has the patient used antihistamine eye drops within the last 14 days? **(cmantih)**

**Patient is ineligible**

( )1 Yes

( )0 No