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