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| ***Instructions: This form is to be completed by the DREAM Clinic Coordinator by directly questioning the patient at every in-office study visit beginning with the month 03 Visit.*** |

1. Have you used artificial tears or gel in the last week? (opatears)

a. About how many times a day did you use tears or gel? (check one) **(opuset)**

 ( )1 1-2 times

 ( )2 3-4 times

 ( )3 5-10 times

 ( )4 greater than 10 times

( )0 No

( )1 Yes

2. Have you used lubricating ointment in the last week? (opoint)

a. About how many times a day did you use lubricating ointment? (check one) (opuseo)

 ( )1 1 time

 ( )2 2 times

 ( )3 3 times

 ( )4 greater than 3 times

( )0 No

( )1 Yes

3. Have you used any of the following over-the-counter treatments for dry eye in the last week?

 a. Lid scrubs (oplids) ( )0 No ( )1 Yes

 b. Baby Shampoo (opsham) ( )0 No ( )1 Yes

 c. Warm Lid soaks (opwlid) ( )0 No ( )1 Yes

 d. Other OTC treatments (opootc) ( )0 No ( )1 Yes

 1. Specify, other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (opotcs)

4. Have you used Restasis in the last week? (oprest)

1. How many times per day did you use Restasis in each eye? (check one for each eye) **(oprert) (oprele)**

Right eye Left eye

 None ( )0 ( )0

 1 time ( )1 ( )1

 2 times ( )2 ( )2

 3 times ( )3 ( )3

 > 3 times ( )4 ( )4

( )0 No

( )1 Yes

5. Have you used autologous serum eye drops in the last week? (opasdr)

( )0 No

1. Check which eye drops were used (check all that apply)

 ( )1 a. Steroid eye drops (opsted)

 ( )1 b. Antibiotic eye drops (opaned)

 ( )1 c.Allergy eye drops (opaled)

 ( )1 d. Combination Steroid

 and Antibiotic

 eye drops(opcsan)

 ( )1 e. Other specify **(opdroth)**

**(opdrots)**

( )1 Yes

6. Have you used other eye drops in the last week? **(opprey)**

( )0 No

( )1 Yes

7. Have you used prescription pills for dry eye such as doxycycline, Oracea, Vibramycin, Doryx or Monodox in the last week? (cmdryeye)

If yes, check which pills were used

 ( )1 a. Doxycycline (cmdoxy)

 ( )1 b. Tetracycline (cmtetr)

 ( )1 c. Minocycline (cmmino)

 ( )1 d. Oracea (cmorac)

 ( )1 e. Monodox (cmmono)

 ( )1 f. Vibramycin (cmvibr)

 ( )1 e. Other pills for dry

 eye, specify: (cmoths)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (coval)

( )0 No

( )1 Yes

8. Do you have punctal plugs in place? (oppunc)

( )0 No

( )1 Yes

9. Do you have a Prokera amniotic membrane device in place? (opprok)

( )0 No

( )1 Yes

10. Have you used Lacriserts in the last week? (oplacr)

( )0 No

( )1 Yes

11. Have you used LipiFlow or intense light treatment in the last week? (oplipi)

( )0 No

( )1 Yes

12. Have you used any other treatment for dry eye

 In the last week? (opothe)

a. If yes, specify: (opoths)

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

( )0 No

( )1 Yes

13. Last name and certification number of person who completed this form

a. PRINT last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (qclname)

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

14. Date Form Completed (qccompdtc)

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Month Day Year