

PATIENT SELF-EVALUATION REPORT FORM

Patient's Name _____ Date _____

Time of Day Form Completed _____ AM/PM

1. Please evaluate your dry eye and sinus/allergy symptoms in the evening immediately before you go to bed (check appropriate column in Table below after first referring to previous days score(s). If your symptom is not listed, please describe in space provided at the bottom of the Table under Other Symptom)

Symptom*	Left Eye				Right Eye			
	0	1	2	3	0	1	2	3
<u>Dry Eye</u>								
Dryness	—	—	—	—	—	—	—	—
Redness	—	—	—	—	—	—	—	—
itching	—	—	—	—	—	—	—	—
Burning	—	—	—	—	—	—	—	—
Sandy Feeling	—	—	—	—	—	—	—	—
Foreign Body Sensation	—	—	—	—	—	—	—	—
Watery Eyes	—	—	—	—	—	—	—	—
Light Sensitivity	—	—	—	—	—	—	—	—
Reduced Visual Acuity	—	—	—	—	—	—	—	—

<u>Sinus/Allergy</u>	0	1	2	3
Sinus Congestion	—	—	—	—
Sinus Headache	—	—	—	—
Nasal Congestion	—	—	—	—
Postnasal Drip	—	—	—	—
Sneezing	—	—	—	—
Chronic Cough	—	—	—	—

Other Symptom(s) (Please describe and grade from 1 to 3):

*Symptoms are graded from 0 to 3, with 0 representing absent, 1 mild, 2 moderate, and 3 severe.

2. Did you use lubricating eye drops, or take any prescription or nonprescription medications today? (Please list and include the dose and number of times taken) _____
