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)

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

Sinus/Allergy	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) _____