OHTS Symptom Checklist: SY

Coordinating Center Use Only

Received..

Logged..

Checked ....

Entered ....

Patient ID: [ ][ ] [ ][ ][ ][ ][ ] [ ][ ][ ] 9

Date: [ ][ ] / [ ][ ] / [ ][ ] 19
mm dd yy

Instructions to Patient:

- Please complete this form about your eyes and general health.
- If you have any questions, please talk to ________________________.
- Thank you very much for your cooperation.

1. Have you been bothered by the following eye problems in the last 7 days?

Not at all: **Unaware of any problems**
A Little: **Noticeable, but easily tolerated**
Somewhat: **Interferes with usual activity**
A Lot: **Cannot work or cannot do usual activities**

Circle one number on each line.	Not at All	A Little	Somewhat	A Lot	
a. Burning, smarting, stinging	1	2	3	4	25
b. Tearing/watering	1	2	3	4	26
c. Dryness	1	2	3	4	27
d. Itching	1	2	3	4	28
e. Soreness, tiredness	1	2	3	4	29
f. Blurry or dim vision	1	2	3	4	30
g. Feeling of something in your eye	1	2	3	4	31
h. Hard to see in daylight	1	2	3	4	32
i. Hard to see in dark places	1	2	3	4	33
j. Halos around lights	1	2	3	4	34
k. Changes to eye color	1	2	3	4	35
l. Changes to eyelashes	1	2	3	4	36
m. Eyelid skin darkening	1	2	3	4	37

Instructions to Coordinator:

- If patient did not complete SY for this visit check here ☐1 38
- Return only this page with CC certification initials CC: [ ][ ][ ] 39

END01

OHTS Symptom Checklist: SY

Patient ID: [ ][ ] [ ][ ][ ][ ][ ] [ ][ ][ ] 9

Date: [ ][ ] / [ ][ ] / [ ][ ] 19
mm dd yy

2. Have you been bothered by any of the following problems in the last 7 days?

Circle one number on each line.	**Not at All**	**A Little**	**Somewhat**	**A Lot**	
a. Difficulty sleeping	1	2	3	4	25
b. Upset stomach	1	2	3	4	26
c. Diarrhea	1	2	3	4	27
d. Headache	1	2	3	4	28
e. Headache above your eyes	1	2	3	4	29
f. Wheezing/trouble breathing	1	2	3	4	30
g. Shortness of breath	1	2	3	4	31
h. Heart skipping beats or irregular heartbeat	1	2	3	4	32
i. Trouble concentrating	1	2	3	4	33
j. Feeling blue or depressed	1	2	3	4	34
k. Impotence or less interest in sex than usual	1	2	3	4	35
l. Food tastes different, metallic	1	2	3	4	36
m. Numbness or tingling in arms, legs, hands, or feet	1	2	3	4	37
n. Weakness	1	2	3	4	38
o. Dizziness	1	2	3	4	39

3. Have you been hospitalized since your last visit? ☐1 Yes ☐2 No 40

Reviewed by (PI or CC): [ ][ ][ ] 41

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