OHTS Symptom Checklist: SY

Patient ID: ☐☐ ☐☐☐☐☐

Visit Date: ☐☐/☐☐/☐☐
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
b. Tearing/watering	1	2	3	4
c. Dryness	1	2	3	4
d. Itching	1	2	3	4
e. Soreness, tiredness	1	2	3	4
f. Blurry or dim vision	1	2	3	4
g. Feeling of something in your eye	1	2	3	4
h. Hard to see in daylight	1	2	3	4
i. Hard to see in dark places	1	2	3	4
j. Halos around lights	1	2	3	4
k. Changes to eye color	1	2	3	4
l. Changes to eyelashes	1	2	3	4
m. Eyelid skin darkening	1	2	3	4

Instructions to Coordinator:
Return only this page with CC certification initials CC: ☐☐☐