Participant ID: _____Participant Initials:_____ Date:_____ Visit_____

Self-reported discomfort

1. How do your eyes feel today?

Bad Great

2. Do you feel any itchiness near your eyes?

Very Itchy Not at all itchy

3. Is your vision blurry?

Very blurry Not at all blurry

4. Do your eyes feel stingy?

Very stingy Not at all stingy

5. Is your eye sore when you are in the light?

Very sore Not at all sore

6. Do you find it difficult to read or write?

Very difficult Not at all difficult

7. When you didn't use the drops, why?_____

_____