SYMPTOMS AND PAIN QUESTIONNAIRE

1. Have you experienced foreign body sensation?

☐ Yes ☐ No If yes, ☐ OD ☐ OS ☐ OU

If yes, did it start immediately after drop instillation?

OD: ☐ Yes ☐ No ☐ Don't remember
OS: ☐ Yes ☐ No ☐ Don't remember

How long did it last?

OD: ☐ 1 min or less ☐ 2 to 5 min ☐ 6-10 min ☐ > 10 min
OS: ☐ 1 min or less ☐ 2 to 5 min ☐ 6-10 min ☐ > 10 min

How severe was it?

OD: ☐ Mild ☐ Moderate ☐ Severe
OS: ☐ Mild ☐ Moderate ☐ Severe

Place a vertical mark on the line below to indicate the severity.

OD

No pain I_____I Very Severe Pain ☐

OS

No pain I_____I Very Severe Pain ☐

2. Have you experienced stinging/burning?

☐ Yes ☐ No If yes, ☐ OD ☐ OS ☐ OU

If yes, did it start immediately after drop instillation?

OD: ☐ Yes ☐ No ☐ Don't remember
OS: ☐ Yes ☐ No ☐ Don't remember

How long did it last?

OD: ☐ 1 min or less ☐ 2 to 5 min ☐ 6-10 min ☐ > 10 min
OS: ☐ 1 min or less ☐ 2 to 5 min ☐ 6-10 min ☐ > 10 min

How severe was it?

OD: ☐ Mild ☐ Moderate ☐ Severe
OS: ☐ Mild ☐ Moderate ☐ Severe

Place a vertical mark on the line below to indicate the severity.

OD

No pain |_____| Very Severe Pain ☐

OS

No pain |_____| Very Severe Pain ☐

3. Have you experienced any pain/discomfort?

☐ Yes ☐ No If yes, ☐ OD ☐ OS ☐ OU

If yes, did it start immediately after drop instillation?

OD: ☐ Yes ☐ No ☐ Don't remember

OS: ☐ Yes ☐ No ☐ Don't remember

How long did it last?

OD: ☐ 1 min or less ☐ 2 to 5 min ☐ 6-10 min ☐ > 10 min

OS: ☐ 1 min or less ☐ 2 to 5 min ☐ 6-10 min ☐ > 10 min

How severe was it?

OD: ☐ Mild ☐ Moderate ☐ Severe

OS: ☐ Mild ☐ Moderate ☐ Severe

Place a vertical mark on the line below to indicate the severity.

OD

No pain |_____| Very Severe Pain ☐

OS

No pain |_____| Very Severe Pain ☐

PATIENT SATISFACTION

1. **Overall, how satisfied have you been with the results of your cataract surgery in your …?**

OD	**OS**
☐ Very dissatisfied	☐ Very dissatisfied
☐ Dissatisfied	☐ Dissatisfied
☐ Neither satisfied nor dissatisfied	☐ Neither satisfied nor dissatisfied
☐ Satisfied	☐ Satisfied
☐ Very satisfied	☐ Very satisfied

2. **Given your postoperative vision/outcome, if you had to do it all over again, would you select:**
   - ☐ LessDrops
   - ☐ 3-Drops

3. **Given your postoperative experience, if you had to do it all over again, would you select:**
   - ☐ LessDrops
   - ☐ 3-Drops