Appendix 1: Subjective Ratings of Ocular Symptoms

| Date ________ | Study _____ | Limbal Clearance Study | Investigator ______ | ID ______ | Lens 1 and 2 |

The following questions relate to a number of symptoms which you may or may not be experiencing with the contact lenses you are wearing in the study. Please select a value between 0 and 100 which most adequately describes how you feel about your study lenses and enter this in the box next to each question’s scale. R=right eye; L=left eye.

1. How would you rate your comfort with your study lenses?
   - 0 Very poor comfort
   - 100 excellent comfort

2. How would you rate your dryness with your study lenses?
   - 0 Very dry
   - 100 not dry at all

3. How would you rate burning with your study lenses?
   - 0 Severe burning
   - 100 no burning

4. How would you rate your clarity of vision with respect to cloudy/filminess (blinking to clear) with your study lenses?
   - 0 Very poor
   - 100 excellent
   (constantly having to blink to clear) (never having to blink to clear)

Comments:

Signed ___________________________ Date ____________