***Note**: To be completed by the clinic coordinator at the patient's last visit.*

1. Do you remember which eye was treated with the laser when you entered CAPT?
   ( )$_1$ Yes ( )$_0$ No

   1.A. Which eye was treated?
   a. Right ( )$_0$
   b. Left ( )$_1$

2. We are interested in how frequently cholesterol levels are checked in CAPT patients. Which best describes you? (Please check only one.)

   Cholesterol checked every year for the past five years. ( )$_1$
   Cholesterol has been checked periodically over the last five years, but not every year. ( )$_2$
   Cholesterol hasn't been checked in the past 5 years ( )$_3$
   Can't remember ( )$_4$

3. Have you ever taken medicine to lower your cholesterol?
   ( )$_1$ Yes ( )$_0$ No ( )$_2$ Can't Remember

   3.A. Fill in year of start and end. Use the patient's best approximate year. Use 2005 or 2006 for End Date if currently taking medication.

	a. Start Date (y y y y)	b. End Date (y y y y)
1. Lipitor	__ __ __ __	__ __ __ __
2. Zocor	__ __ __ __	__ __ __ __
3. Pravachol	__ __ __ __	__ __ __ __
4. Mevacor	__ __ __ __	__ __ __ __
5. Lescol	__ __ __ __	__ __ __ __
6. Crestor	__ __ __ __	__ __ __ __
7. Lopid	__ __ __ __	__ __ __ __
8. Questran	__ __ __ __	__ __ __ __
9. Niacor	__ __ __ __	__ __ __ __
Other: Please specify below:		
10._____	__ __ __ __	__ __ __ __
11._____	__ __ __ __	__ __ __ __

4. Was the patient phakic **at entry into CAPT?**
   Review patient's chart and confirm history with patient.
   a. Right eye: ( )$_1$ Yes ( )$_0$ No
   b. Left eye: ( )$_1$ Yes ( )$_0$ No

5. Print name and certification number of person who completed this form:

   _____ / __ __ __ __
   First Name Last Name Cert#

6. Date Exit Interview was completed:

   __ __ / __ __ / __ __ __ __
   Month Day Year

Coord Ctr Use Only: Initials__ __ __
Date: __ __ - __ __ - __ __ __ __

Visit __ __
Form: XF

ID No.: __ __ - __ __ __ - C
Name Code: __ __ __ __ __