Date completed
(DD/MM/YYYY): _____
(This must be filled in)

Questionnaire about Eye Symptoms and Daily Life

This questionnaire asks about how much you experience various eye symptoms, and also what kind of problems you experience in your daily life. Your answers will be used to inform future medical care. Please do not think too hard about the questions; just answer based on what you feel.

◇ **For each question below, circle one response from 0-4 in Column A.**
- **If your answer is 0 ("Never") in Column A ➜ Move onto the next question.**
- **If your answer is 1-4 in Column A ➜ Also circle one from 1-4 in Column B.**

Please answer <u>all</u> questions without missing any.

◆ <u>During the past 7 days,</u> did you experience the following symptoms?	Column A						Column B			
	Never	Occasionally	Sometimes	Often	Always		Hardly bothered me	Bothered me a little	Bothered me	Bothered me very much
1) Grittiness (sensation of something in your eye)	0	1	2	3	4	➜	1	2	3	4
2) Dry eyes	0	1	2	3	4	➜	1	2	3	4
3) Sore eyes	0	1	2	3	4	➜	1	2	3	4
4) Tired eyes	0	1	2	3	4	➜	1	2	3	4
5) Heavy eyelids	0	1	2	3	4	➜	1	2	3	4
6) Red eyes	0	1	2	3	4	➜	1	2	3	4

Go to the next questions ↗

- If your answer is 0 ("Never") in Column A ➜ Move onto the next question.
- If your answer is 1-4 in Column A ➜ Also circle one from 1-4 in Column B.

◆ During the past 7 days, did you experience the following?	Column A: Never	Occasionally	Sometimes	Often	Always		Column B: Hardly bothered me	Bothered me a little	Bothered me	Bothered me very much
7) Difficulty keeping my eyes open (due to my symptoms)	0	1	2	3	4	➜	1	2	3	4
8) Vision became blurry when engaging in activities that required sustained visual attention (e.g. computer working, reading, knitting, etc.)	0	1	2	3	4	➜	1	2	3	4
9) Light was too bright	0	1	2	3	4	➜	1	2	3	4
10) Eye symptoms worsened when reading newspapers, magazines or books	0	1	2	3	4	➜	1	2	3	4
11) Eye symptoms worsened when watching TV or when using a computer/mobile phone	0	1	2	3	4	➜	1	2	3	4
12) Eye symptoms reduced my ability to concentrate	0	1	2	3	4	➜	1	2	3	4
13) Eye symptoms interfered with work, housework or studying	0	1	2	3	4	➜	1	2	3	4
14) Tended to avoid leaving the house because of eye symptoms	0	1	2	3	4	➜	1	2	3	4
15) Felt down due to eye symptoms	0	1	2	3	4	➜	1	2	3	4

◇ Finally, please tell us how you have been overall for the past week, including your eye symptoms and how they have affected your daily life.
From the responses below, please circle the number that best describes your condition.

1	2	3	4	5	6
Extremely good	Very good	Good	Bad	Very bad	Extremely bad

Thank you for completing the questionnaire.