Contact Lens & Dry eye Questionnaire

Long Form

1. Contact Lens Comfort:

a. During a typical day in the past week, **how often** did your eyes feel uncomfortable while wearing your contact lenses?

1 Never (SKIP TO QUESTION 2)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

When your eyes felt uncomfortable, **how intense** was this feeling of discomfort…

b. Within the first two hours of putting in your lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

2. Dryness:

a. During a typical day in the past week, **how often** did your eyes feel dry while wearing your contact lenses?

1 Never (SKIP TO QUESTION 3)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

When your eyes felt dry, **how intense** was the feeling of dryness…

b. Within the first two hours of putting in your lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

3. Blurry Vision:

a. During a typical day in the past week, **how often** did your vision change between clear and blurry while wearing your contact lenses? (e.g., foggy or steamy vision that clears up when you blink.)

1 Never (SKIP TO QUESTION 4)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this blurry vision while wearing your contact lenses?

b. Within the first two hours of putting in your lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

4. Irritation:

a. During a typical day in the past week, **how often** did your eyes feel irritated while wearing your contact lenses?

1 Never (SKIP TO QUESTION 5)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this feeling of irritation while wearing your contact lenses?

b. Within the first two hours of putting in your lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

5. Grittiness:

a. During a typical day in the past week, **how often** did your eyes feel gritty and scratchy while wearing your contact lenses?

1 Never (SKIP TO QUESTION 6)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this feeling of grittiness and scratchiness while wearing your contact lenses?

b. Within the first two hours of putting in your contact lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

6. Feels like something is in your eye:

a. During a typical day in the past week, **how often** did you have the feeling as if “something” was in your eye while wearing your contact lenses?

1 Never (SKIP TO QUESTION 7)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this feeling like something is in your eye while wearing your contact lenses?

b. Within the first two hours of putting in your contact lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

7. Burning & Stinging:

a. During a typical day in the past week, **how often** were your eyes burning and stinging while wearing your contact lenses?

1 Never (SKIP TO QUESTION 8)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this feeling of burning and stinging while wearing your contact lenses?

b. Within the first two hours of putting in your contact lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

8. Light sensitivity:

a. During a typical day in the past week, **how often** did your eyes feel unusually sensitive to bright lights while wearing your contact lenses?

1 Never (SKIP TO QUESTION 9)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this light sensitivity while wearing your contact lenses?

b. Within the first two hours of putting in your contact lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

9. Itching:

a. During a typical day in the past week, **how often** did your eyes itch while wearing your contact lenses?

1 Never (SKIP TO QUESTION 10)
2 Infrequently
3 Occasionally
4 Frequently
5 Constantly

On average, **how intense** was this feeling of itchiness while wearing your contact lenses?

b. Within the first two hours of putting in your contact lenses?

Not at All Intense				Very Intense
1	2	3	4	5

c. In the middle of the day?

Not at All Intense				Very Intense
1	2	3	4	5

d. At the end of the day?

Not at All Intense				Very Intense
1	2	3	4	5

10. Do you think you have dry eyes while wearing your contact lenses?

1 Yes

2 No

3 Unsure

Thank you!