Allogenic Serum Eye Drops:
Patient Questionnaire

Thank you very much for taking the time to complete this questionnaire. We are keen to understand patients' experiences of using serum eye drops to treat their eye conditions and we will be very appreciative of your responses.

Please read the following instructions carefully:

For most questions, please mark a cross ☒ clearly inside one box using a black or blue pen. For some questions, you will be provided with different directions. Please only select one answer for each question.

Don't worry if you make a mistake – please fill in the box ■ and mark a cross ☒ in the correct box.

Please do not write your name or address on the questionnaire. Your answers will be anonymised.

Please return the completed questionnaire by post, using the pre-paid envelope provided.

If you have any questions or difficulties with completing the questionnaire, please contact us at cornea.glaucoma@mft.nhs.uk (telephone 0161 276 5522, opening hour 9am – 4pm)

ABOUT YOUR CONDITION

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light?					
2. Eyes that feel gritty?					
3. Painful or sore eyes?					
4. Blurred vision?					
5. Poor vision?					

HAVE PROBLEMS WITH YOUR EYES LIMITED YOU IN PERFORMING ANY OF THE FOLLOWING *DURING THE LAST WEEK:*

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
6. Driving at night?					
7. Reading?					
8. Working with a computer or bank machine (ATM)?					
9. Watching TV?					

HAVE YOUR EYES FELT UNCOMFORTABLE IN ANY OF THE FOLLOWING SITUATIONS *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
10. Windy conditions?					
11. Places or areas with low humidity (very dry)?					
12. Areas that are air conditioned?					

ABOUT YOUR TREATMENT

13. Do you currently use serum eye drops to treat your eye condition?

☐ Yes

☐ No

14. *Over the last 2 weeks,* how often did you use serum eye drops for your eye condition?

☐ Every day (and if yes, how many times a day? _____ times)

☐ Most days

☐ Half of the days

☐ Less than half of the days

☐ Not at all

Please state to what extent you agree with the following statements:

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
15. I was happy with how quickly my serum eye drops worked					
16. I was happy with how long the effects of my serum eye drops lasted					
17. The serum eye drops I used completely eliminated my dry eye symptoms					
18. The serum eye drops I used relieved most of my dry eye symptoms					
19. I was bothered by how often I had to use serum eye drops					
20. I was bothered by blurriness shortly after using my serum eye drops					
21. I was embarrassed when I had to use my serum eye drops					

22. As a result of using serum eye drops, have you ever experienced any side effects?

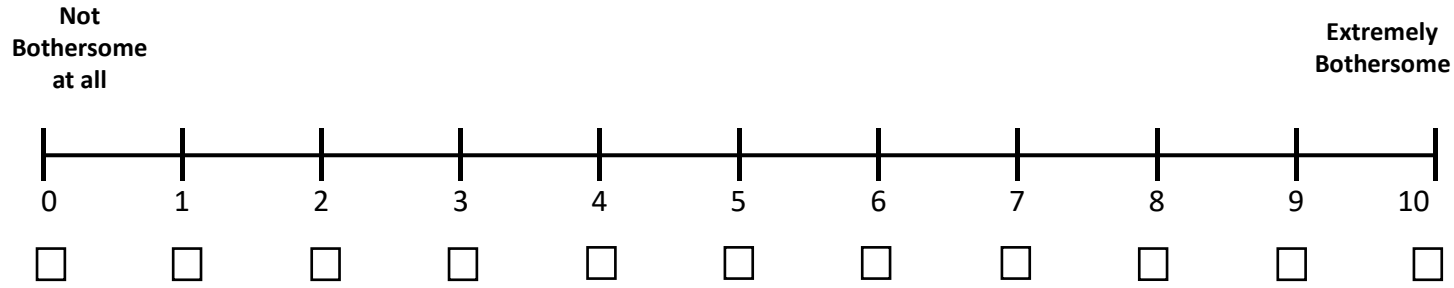
☐ Yes

☐ No

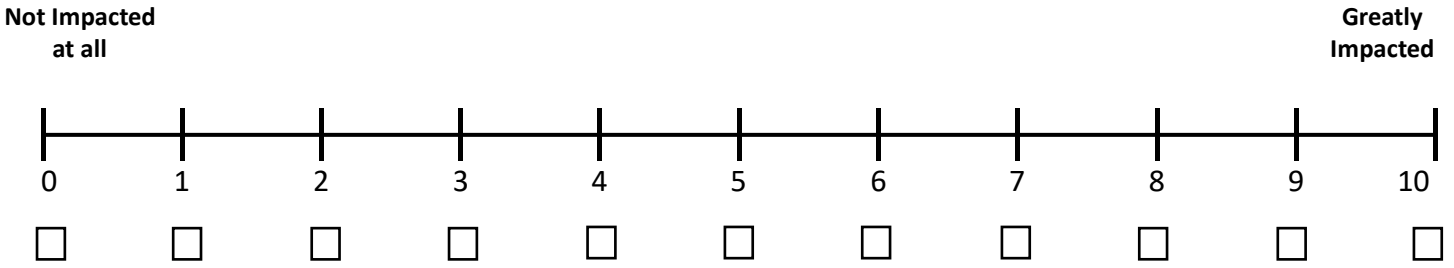
23. If you answered “Yes” to question 21, please provide us with details of the side effects that you experience:

Please grade the following questions using the scales of 0-10 shown below by placing a CROSS (X) in the box (☐) corresponding to your opinion:

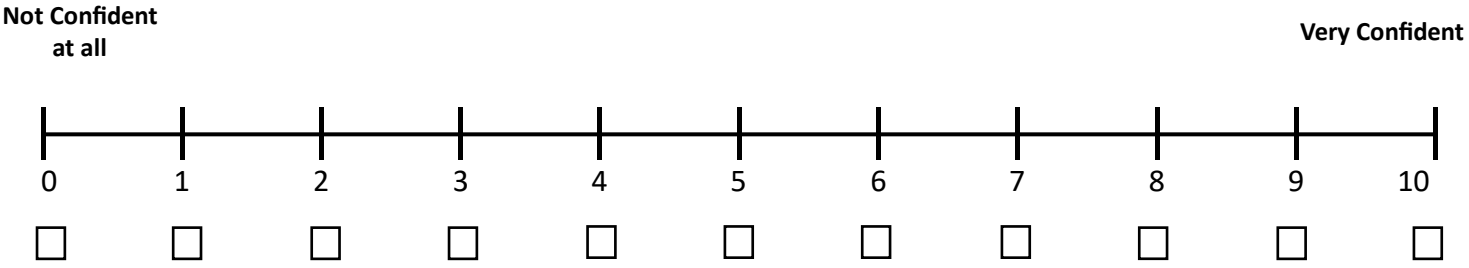
24. How bothersome are the side effects that you experience? (If you do not experience any side effects, please move on to **question 26)**



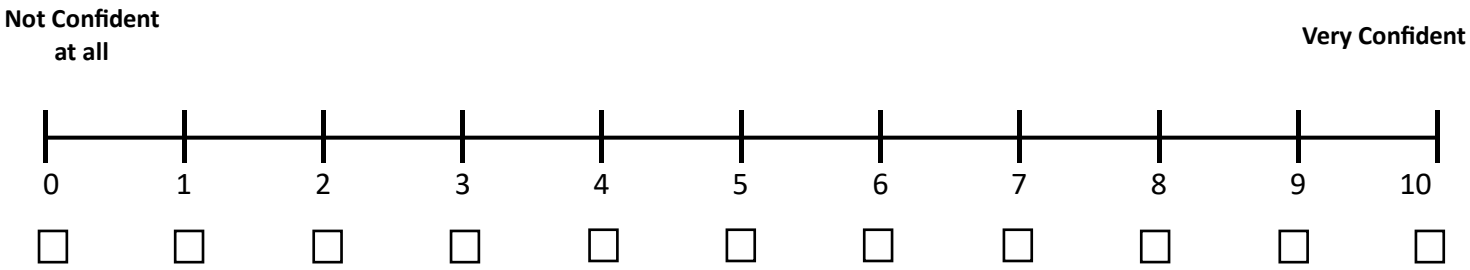
25. To what degree have side effects impacted your overall satisfaction with serum eye drops?



26. How confident are you with how to administer serum eye drops?



27. Do you feel confident that you have a good understanding of the reasons you were prescribed serum eye drops?



28. Do you require assistance with administering serum eye drops?

☐ Yes

☐ No

☐ Sometimes

29. Do you feel that the size of the serum eye drop vials is:

☐ More than required

☐ Just ideal

☐ Insufficient

30. Do you feel that the number of serum eye drop vials given to you at a time is:

☐ More than required

☐ Just ideal

☐ Insufficient

YOUR OVERALL VIEWS

Please grade the following questions according to your degree of satisfaction by circling the appropriate face image:

31. How satisfied are you that the symptoms of your eye condition have improved with the use of serum eye drops?

Completely satisfied

Not satisfied at all

32. How satisfied are you that there has been a positive impact on your quality of life with the use of serum eye drops?

Completely satisfied

Not satisfied at all

33. Overall how satisfied are you with the use of serum eye drops to treat your eye condition?

Completely satisfied

Not satisfied at all

34. If you are dissatisfied with how well your serum eye drops have worked, please let us know why in the space below:

35. Have you stopped using serum eye drops?

☐ Yes

☐ No

36. If you answered “Yes” to the previous question, please detail the reason/s why in the space below:

37. If you have experienced any issues with serum eye drops that have not been covered, please describe them in the space below:

38. If you have any other comments about your experience with serum eye drops, please let us know in the space below: