

## ANNEXURE B. Patient Questionnaire

Please answer the questions below. Choose or write one answer for each item.

This form takes about 5 mins.

### A. About You

Patient Code (if provided by clinic:

1) Age (years):

2) Sex ☐ Male ☐ Female ☐ Prefer not to say

3) Occupation:

### B. Screen Use

3) On average, how many hours per day do you spend using screens (computer/phone/tablet)?

☐ 0–2 h ☐ 2–4 h ☐ 4–6 h ☐ 6–8 h ☐ 8–10 h ☐ 10+ h

4) On work/study days vs. weekends (optional):

Work/Study days: ☐ 0–2 h ☐ 2–4 h ☐ 4–6 h ☐ 6–8 h ☐ 8–10 h ☐ 10+ h

Weekend days: ☐ 0–2 h ☐ 2–4 h ☐ 4–6 h ☐ 6–8 h ☐ 8–10 h ☐ 10+ h

### C. Eye Symptoms

5) For how many months have you experienced your eye symptoms?

6) Overall symptom severity (circle one):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7) Which symptoms do you have? (tick all that apply)

☐ Dryness

☐ Burning

☐ Grittiness/sandiness

☐ Tearing

☐ Itching

☐ Light sensitivity

☐ Blurred vision (intermittent)

☐ Headache

☐ Other:

D. Treatments Used (tick all that apply)

☐ Artificial tears

☐ Gel/ointment

☐ Warm compresses

☐ Lid hygiene

☐ Omega-3 supplements

☐ Prescription drops

☐ Punctal plugs

☐ Other:

### E. Response to Treatment

8) How did your symptoms respond to treatment?

☐ Improved ☐ Stable ☐ Worsened ☐ Not treated

### F. Follow-up

9) If you had a follow-up visit, how many days after the first visit was it?