SECTION A: GENERAL QUESTIONS

A1. Today's date

Day Month Year

A2. What is your birth month and birth year?

Month Year

A3. What is your sex?

- ☐ Male
- ☐ Female

A4. What is your ethnicity? You can put an [X] in more than one box, if applicable.

- ☐ Caucasian
- ☐ Latino/Hispanic
- ☐ Middle Eastern
- ☐ African
- ☐ Caribbean
- ☐ South Asian
- ☐ East Asian
- ☐ Other _____

A5. What is the highest level of education you have achieved?

Look for your highest degree in education and fill in an x in the box.

- ☐ No certificate, diploma or degree
- ☐ High school diploma or equivalency certificate
- ☐ Trades: Certificate or diploma (excluding certificate of apprenticeship)
- ☐ Trades: Certificate of Apprenticeship or Certificate of Qualification
- ☐ College, CEGEP or other non-university certificate or diploma
- ☐ University: Certificate or diploma BELOW bachelor level
- ☐ University: Certificate, diploma or degree AT bachelor level
- ☐ University: Certificate, diploma or degree ABOVE bachelor level

A6. What is your employment status? *Place an* [X] *in the box for what you usually do.*

- ☐ I am employed
- ☐ I am unemployed – looking for a job
- ☐ I am unemployed – not looking for a job
- ☐ I am on disability leave from work due to Dry Eye Disease (DED)
- ☐ I am on disability leave from work due to other reasons
- ☐ I am retired or on a pre-pension plan
- ☐ I do something else, namely: _____

SECTION B: HEALTH QUESTIONS

B1. Do you smoke?

- ☐ Previous smoker, but stopped
- ☐ Yes – current smoker
- ☐ No – never smoked

B2. Are you currently pregnant?

- ☐ Yes
- ☐ No

B3. Do you wear contact lenses?

- ☐ Yes
- ☐ No

B4. How many hours per day do you estimate you spend looking at a screen?

(TV, phone, iPad/tablet, computer, etc.)

- ☐ 0 hours
- ☐ Less than 1 hour, more than 0
- ☐ 1-2 hours
- ☐ 3-4 hours
- ☐ 5-6 hours
- ☐ Other: _____ hours

B5. Which type of treatment are you currently applying to your eyes?

Select all that apply.

- ☐ Preserved
- ☐ Non-preserved *(ex. Lacrisert)*
- ☐ Prescription eye drops *(ex. Xiidra, Restasis)*
- ☐ Specialty drugs
- ☐ Compounded ointments
- ☐ Gel *(ex. Lotemax)*
- ☐ Other _____
- ☐ I don't know
- ☐ None

B6. What other medications are you currently taking? *Select all that apply.*

- ☐ Anti-depressants
- ☐ Anti-Cholinergics (e.g. Parkinson's medications, antisychotics, sleeping pills)
- ☐ Antihistamines
- ☐ Anti-anxiety
- ☐ Botox
- ☐ Hormone replacement therapy
- ☐ Isotretinoin (e.g. Accutane)
- ☐ Multivitamins
- ☐ Beta blockers
- ☐ Oral contraceptives
- ☐ Diuretics
- ☐ Chemotherapy/radiation therapy
- ☐ Other _____
- ☐ I don't know
- ☐ None

B7. Have you been formally diagnosed with Sjögren syndrome?

- ☐ Yes
- ☐ No
- ☐ I don't know

B8. Do you currently have any of the following conditions? *Select all that apply.*

- ☐ Androgen deficiency
- ☐ Autoimmune diseases *(e.g. Sjögren, RA, lupus)*
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hematopoietic stem cell transplantation or Graft vs. Host Disease
- ☐ HIV
- ☐ Irritable Bowel Syndrome
- ☐ Mental health conditions *(i.e. mood, depression, anxiety)*
- ☐ Migraines
- ☐ Rosacea
- ☐ Sick Building Syndrome
- ☐ Thyroid disorder
- ☐ Vitamin A deficiency
- ☐ Other _____
- ☐ None

B9. How long have you been suffering from Dry Eye Disease?

- ☐ For less than 1 year
- ☐ For the past 1-5 years
- ☐ For the past 6-10 years
- ☐ Other _____ years

B10. Other than Dry Eye Disease, do you have any of the following conditions?

Select all that apply.

- ☐ Glaucoma
- ☐ Keratoconus +/- corneal collagen crosslinking
- ☐ Meibomian gland dysfunction
- ☐ Prior conjunctivitis (*pink eye*)
- ☐ Seasonal allergies with itchy eyes
- ☐ Surfer's Eye (*pterygium*)
- ☐ Other _____
- ☐ None

B11. Have you had any ocular surgeries or injections?

- ☐ Glaucoma surgery
- ☐ Cataract
- ☐ Eye lid surgery
- ☐ Refractive eye surgery, including LASIK or PRK
- ☐ Other _____
- ☐ None

SECTION C: EYE DRYNESS SCORE

Visual Analogue Scale (VAS)

Please rate you discomfort with the *Eye Dryness* symptom on a scale from 0 to 100 by placing a vertical mark (|) on the horizontal line indicating your level of eye discomfort

0 corresponds to: "no discomfort"

100 corresponds to: "maximal (the most) discomfort"

Eye Dryness

SECTION D: VISUAL FUNCTIONING QUESTIONNAIRE – 25

The following is a survey with statements about problems which involve your vision or feelings that you have about your vision condition. After each question please choose the response that best describes your situation.

Please answer all the questions as if you were wearing your glasses or contact lenses (if any). Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about vision problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

PART 1 – GENERAL HEALTH AND VISION

1. In general, would you say your overall health is:

(Circle One)

Excellent .....

Very Good .....

Good .....

Fair .....

Poor .....

2. At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

(Circle One)

Excellent .....

Good .....

Fair .....

Poor .....

Very Poor .....

Completely Blind .....

3. How much of the time do you worry about your eyesight?

(Circle One)

None of the time 1
A little of the time 2
Some of the time 3
Most of the time 4
All of the time? 5

4. How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

(Circle One)

None 1
Mild 2
Moderate 3
Severe, or 4
Very severe? 5

PART 2 – DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

5. How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

(Circle One)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

6. How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

7. Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

8. How much difficulty do you have reading street signs or the names of stores?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

9. Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

10. Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

11. Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

12. Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

13. Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

14. Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Stopped doing this because of your eyesight 5**
- **Stopped doing this for other reasons or not interested in doing this 6**

15. Are you currently driving, at least once in a while?

(Circle One)

Yes	**1**	*Skip To Q 15c*
No	**2**	

15a. IF NO: Have you never driven a car or have you given up driving?

(Circle One)

Never drove	**1**	*Skip To Part 3, Q 17*
Gave up	**2**	

15b. IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

(Circle One)

Mainly eyesight	**1**	*Skip To Part 3, Q 17*
Mainly other reasons	**2**	*Skip To Part 3, Q 17*
Both eyesight and other reasons	**3**	*Skip To Part 3, Q 17*

15c. IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

(Circle One)

No difficulty at all	**1**
A little difficulty	**2**
Moderate difficulty	**3**
Extreme difficulty	**4**

16. How much difficulty do you have driving at night? Would you say you have:

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Have you stopped doing this because of your eyesight 5**
- **Have you stopped doing this for other reasons or are you not interested in doing this 6**

16A. How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

(Circle One)

- **No difficulty at all 1**
- **A little difficulty 2**
- **Moderate difficulty 3**
- **Extreme difficulty 4**
- **Have you stopped doing this because of your eyesight 5**
- **Have you stopped doing this for other reasons or are you not interested in doing this 6**

PART 3: RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, please circle the number to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

READ CATEGORIES:	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	(Circle One On Each Line)				
17. Do you accomplish less than you would like because of your vision?	1	2	3	4	5
18. Are you limited in how long you can work or do other activities because of your vision?	1	2	3	4	5
19. How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:	1	2	3	4	5

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

	(Circle One On Each Line)				
	Definitely True	**Mostly True**	**Not Sure**	**Mostly False**	**Definitely False**
20. I stay home most of the time because of my eyesight	1	2	3	4	5
21. I feel frustrated a lot of the time because of my eyesight	1	2	3	4	5
22. I have much less control over what I do, because of my eyesight	1	2	3	4	5
23. Because of my eyesight, I have to rely too much on what other people tell me	1	2	3	4	5
24. I need a lot of help from others because of my eyesight	1	2	3	4	5
25. I worry about doing things that will embarrass myself or others, because of my eyesight	1	2	3	4	5

SECTION E: WORK PRODUCTIVITY AND ACTIVITY IMPAIRMENT QUESTIONNAIRE

The following questions ask about the effect of your **Dry Eye Disease (DED)** on your ability to work and perform regular activities. *Please fill in the blanks or circle a number, as indicated.*

1. **Are you currently employed (working for pay)? _____ NO ___ YES**
   If NO, check "NO" and skip to question 6.

The next questions are about the **past seven days**, not including today.

2. **During the past seven days, how many hours did you miss from work because of problems associated with your DED? Include hours you missed on sick days, times you went in late, left early, etc., because of your DED. Do not include time you missed to participate in this study.**

_____ HOURS

3. **During the past seven days, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?**

_____HOURS

4. **During the past seven days, how many hours did you actually work?**

_____HOURS (If "0", skip to question 6.)

5. **During the past seven days, how much did your DED affect your productivity while you were working?**

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If DED affected your work only a little, choose a low number. Choose a high number if DED affected your work a great deal.

Consider only how much DED affected productivity while you were working.

DED had no effect on my work	0	1	2	3	4	5	6	7	8	9	10	DED completely prevented me from working

CIRCLE A NUMBER

6. **During the past seven days, how much did your DED affect your ability to do your regular daily activities, other than work at a job?**

By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If DED affected your activities only a little, choose a low number. Choose a high number if DED affected your activities a great deal.

Consider only how much DED affected your ability
to do your regular daily activities, other than work at a job.

DED had no effect on my daily activities	0	1	2	3	4	5	6	7	8	9	10	**DED completely prevented me from doing my daily activities**

CIRCLE A NUMBER

SECTION F: OUT-OF-POCKET EXPENSES

We want to better understand the financial burden that your Dry Eye Disease is having on you. The following questions ask about the amount of money you spend out of your own pocket when buying treatments such as eye drops or supplements, and any extra money you spend to see your ophthalmologist/optometrist.

RESOURCE A: Over-the-Counter Ocular Lubricants - Artificial tears
(Examples: Systane, Refresh, Blink, Bion, Hydrasense, Hylo)

1. Have you used NON-PRESCRIPTION ARTIFICIAL TEARS in the past 3 (THREE) months?

- ☐ Yes
- ☐ No – *skip to RESOURCE B, Question #5*

2. If so, how often do you usually use NON-PRESCRIPTION ARTIFICIAL TEARS daily?

- ☐ 1-2 times a day
- ☐ 3-4 times a day
- ☐ 5-6 times a day
- ☐ Other: ____ times a day
- ☐ I don't know

3. Are you paying for NON-PRESCRIPTION ARTIFICIAL TEARS out-of-pocket?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE B, Question #5*
- ☐ I don't know

4. If so, how much money PER ONE MONTH are you typically spending on NON-PRESCRIPTION ARTIFICIAL TEARS?

- ☐ $10-19 per month
- ☐ $20-29 per month
- ☐ $30-39 per month
- ☐ $40-49 per month
- ☐ Other: $____ per month
- ☐ I don't know

RESOURCE B: Over-the-Counter Ocular Lubricants - Gels or ointments
(Example: Teargel, Duolube, Lacrilube, Ocunox)

5. Have you used NON-PRESCRIPTION OCULAR GELS/OINTMENTS in the past 3 (THREE) months?

- ☐ Yes
- ☐ No – *skip to RESOURCE C, Question #9*

6. If so, how often do you usually use NON-PRESCRIPTION OCULAR GELS/OINTMENTS daily?

- ☐ 1-2 times a day
- ☐ 3-4 times a day
- ☐ 5-6 times a day
- ☐ Other: ____ times a day
- ☐ I don't know

7. Are you paying for NON-PRESCRIPTION OCULAR GELS/OINTMENTS out-of-pocket?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE C, Question #9*
- ☐ I don't know

8. If so, how much money PER ONE MONTH are you typically spending on NON-PRESCRIPTION OCULAR GELS/OINTMENTS?

- ☐ $10-19 per month
- ☐ $20-29 per month
- ☐ $30-39 per month
- ☐ $40-49 per month
- ☐ $50-59 per month
- ☐ Other: $____ per month
- ☐ I don't know

RESOURCE C: Prescription Ocular Lubricants
(Example: serum tears, amniotic fluid extract (Regenereyes), albumin drops (specifically from princess Margaret hospital).

9. Have you used PRESCRIPTION OCULAR LUBRICANT in the past 3 (THREE) months?

- ☐ Yes
- ☐ No – *skip to RESOURCE D, Question #13*

10. If so, how often do you usually use PRESCRIPTION OCULAR LUBRICANT daily?

- ☐ 1-2 times a day
- ☐ 3-4 times a day
- ☐ 5-6 times a day
- ☐ Other: ____ times a day
- ☐ I don't know

11. Are you paying for PRESCRIPTION OCULAR LUBRICANT out-of-pocket?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE D, Question #13*
- ☐ I don't know

12. If so, how much money PER ONE MONTH are you typically spending on PRESCRIPTION OCULAR LUBRICANT?

- ☐ $40-49
- ☐ $59-149
- ☐ $150-169
- ☐ Other: $____ per month
- ☐ I don't know

RESOURCE D: Prescription Ocular Anti-inflammatory Agents
(Example: Xiidra, Restasis, Cyclosporine, steroids, lotemax)

13. Have you used PRESCRIPTION OCULAR ANTI-INFLAMMATORY AGENTS in the past 3 (THREE) months?

- ☐ Yes
- ☐ No – *skip to RESOURCE E, Question #17*

14. If so, how often do you usually use PRESCRIPTION OCULAR ANTI-INFLAMMATORY AGENTS daily?

- ☐ 1-2 times a day
- ☐ 3-4 times a day
- ☐ 5-6 times a day
- ☐ Other: ____ times a day
- ☐ I don't know

15. Are you paying for PRESCRIPTION OCULAR ANTI-INFLAMMATORY AGENTS out-of-pocket?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE E, Question #17*
- ☐ I don't know

16. If so, how much money PER ONE MONTH are you typically spending on PRESCRIPTION OCULAR ANTI-INFLAMMATORY AGENTS?

- ☐ $0-$49 per month
- ☐ $50-$99 per month
- ☐ $100-$149 per month
- ☐ $150-$199 per month
- ☐ $200-$249 per month
- ☐ Other: $____ per month
- ☐ I don't know

RESOURCE E: Nutritional Supplements
(Example: fish oil, flax seed oil)

17. Have you used this resource NUTRITIONAL SUPPLEMENTS TO IMPROVE DRY EYE in the past 3 (THREE) months?

- ☐ Yes
- ☐ No – *skip to RESOURCE F, Question #21*

18. If so, how often do you usually use NUTRITIONAL SUPPLEMENTS TO IMPROVE DRY EYE?

- ☐ Everyday
- ☐ Every other day
- ☐ Twice a week
- ☐ Once a week
- ☐ Once a month
- ☐ Other: ___ times per _____
- ☐ I don't know

19. Are you paying for NUTRITIONAL SUPPLEMENTS TO IMPROVE DRY EYE out-of-pocket?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE F, Question #21*
- ☐ I don't know

20. If so, how much money PER ONE MONTH are you typically spending on NUTRITIONAL SUPPLEMENTS TO IMPROVE DRY EYE?

- ☐ $0-$9 per month
- ☐ $10-$19 per month
- ☐ $20-$29 per month
- ☐ $30-$39 per month
- ☐ $40-$49 per month
- ☐ Other: $____ per month
- ☐ I don't know

RESOURCE F: Punctal Plugs

21. Have you had PUNCTAL PLUGS inserted in one or both of your eyes before?

- ☐ Yes
- ☐ No – *skip to RESOURCE G, Question #25*

22. If so, how many PUNCTAL PLUG implants have you had inserted?
(For example, if you have received 1 implant in each eye, the total number of implants you've receive is 2. If one of those implants fell out and you had to get it replaced, then the total number of implants you've ever had equals 3)

- ☐ Only 1 implant in my life
- ☐ 2 implants in total in my life
- ☐ 3 implants in total in my life
- ☐ 4 implants in total in my life
- ☐ Other: ___ implants
- ☐ I don't know

23. Did you pay for your PUNCTAL PLUG IMPLANTS out-of-pocket?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE G, Question #25*
- ☐ I don't know

24. If so, how much money, on average, did you spend on PUNCTAL PLUG IMPLANTS?

- ☐ $0-$49 per implant
- ☐ $50-$99 per implant
- ☐ $100-$149 per implant
- ☐ $150-$199 per implant
- ☐ $200-$249 per implant
- ☐ Other $_____ per implant
- ☐ I don't know

RESOURCE G: Optometrist Visits

25. Is TODAY your FIRST OPTOMETRIST VISIT for dry eye disease?

- ☐ Yes – *skip to RESOURCE H Question #29*
- ☐ No

26. If NOT, how many times did you VISIT THE OPTOMETRIST in the last 2 (TWO) YEARS for dry eye disease?

- ☐ Twice a year
- ☐ Once a year
- ☐ Once every two years
- ☐ Other: ___ times per ____
- ☐ I don't know

27. Do you pay anything out-of-pocket during these visits to the OPTOMETRIST?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to RESOURCE H, Question #29*
- ☐ I don't know

28. If so, how much money on average PER VISIT?

- ☐ $0-$49 per visit
- ☐ $50-$99 per visit
- ☐ $100-$149 per visit
- ☐ $150-$199 per visit
- ☐ $200-$249 per visit
- ☐ Other $_____ per visit
- ☐ I don't know

RESOURCE H: Ophthalmologist Visits

29. Is TODAY your FIRST OPHTHALMOLOGIST visit for dry eye disease?

- ☐ Yes – *skip to the end of the survey*
- ☐ No

30. If NOT, how often did you VISIT THE OPHTHALMOLOGIST in the last 2 (TWO) YEARS for dry eye disease?

- ☐ Twice a year
- ☐ Once a year
- ☐ Once every two years
- ☐ Other: ___ times per ____
- ☐ I don't know

31. Do you pay anything out-of-pocket to VISIT THE OPHTHALMOLOGIST?

- ☐ Yes, because I either don't have insurance or my insurance does not cover this
- ☐ Partially, since insurance covers some costs
- ☐ No, insurance pays for everything – *skip to the end of the survey*
- ☐ I don't know

32. If so, how much money on average PER VISIT?

- ☐ $0
- ☐ $1-$49 per visit
- ☐ $50-$99 per visit
- ☐ $100-$149 per visit
- ☐ $150-$199 per visit
- ☐ $200-$249 per visit
- ☐ Other $_____ per visit
- ☐ I don't know

That was the last question.

What should you do with the survey now that it is filled in?
Please return the completed survey and return it to your optometrist/ophthalmologist. Please note that all your answers will be treated as strictly confidential.
Thank you very much!