Evaluation of dry eye symptoms and risk factors among medical students

De	ar collegues,
	order to determine the frequency and the impact of different risk factors on the onset and worsening or eye symptoms among medical student we present you with this 3 part questionnaire.
	is survey is completely anonymous. Through completion of this questionnaire, you would help us alyze this problem.
We	e thank you for your cooperation.
If y	you agree with usage of given information in scientific purposes, please check the box below.
	☐ Yes, I agree.
	ease answer the following questions as sincere and objective as possible by choosing one of eavailable answers or by filling the gap beside the questions if needed.
I	
1.	Sex: ☐ Male
	☐ Female
 3. 	Age: Which year of study are you attending?
	□ 1th
	□ 2th
	□ 3th
	□ 4th
	□ 5th
	□ 6th
4.	Do you use contact lenses?
	☐ Yes

	□ No
5.	Do you suffer from allergies?
	□ Yes
	□ No
6.	Do you suffer from any systemic disease?
	□ Yes
	□ No
7.	Do you smoke?
	☐ Yes
	□ No
8.	Do you use contraceptive pills?
	□ Yes
	□ No
II	
9.	How many hours per day do you study?
	□ 0-3h
	□ 3-6h
	☐ More than 6h per day
10.	How many hours per day do spend studying books and hard copy literature?
	\square I do not study using books and hard copy literature.
	□ 0-3h
	□ 3-6h
	☐ More than 6h per day
11.	How many hours per day do study using computer, laptop, and other VD devices?
	☐ I do not study using computer, laptop, and other VD devices.
	□ 0-3h
	□ 3-6h
	☐ More than 6h per day

12. How many hours per day do you spend using mobile phones, computers, laptops, and other VD devices in your free time?							
	☐ I do not use mobile phones, computers, laptops, and other VD devices in my free time.						
□ 0-3h							
□ 3-6h	□ 3-6h						
☐ More than	☐ More than 6h per day						
Ш							
Dlagga granuar th	a fallowing gr	rastions by ab	aakina tha ba	r that best	namagants ag	ah angwar	
Please answer th	e jouowing qi	iesiions by ch	ескінд іне во	x inai vesi i	represents ea	cn answer.	
13. Have you exp	erienced any	of the following	ng during the	last week?			
	All of the	Most of			Some of the	None of the	
1) Eyes that	time	time	_	me ¬	time	time	
are sensitive			L				
to light?							
2) Eyes that			[
feel gritty?							
3) Painful or			[
sore eyes?							
4) Blurred vision?			[
5) Poor vision?			[
14. Have problems with your eyes limited you in performing any of the following during the last week?							
	All of the	Most of the	Half of the	Some of t	he None o	of N/A	
6)Panding?	time	time	time	time	the tim	_	
6)Reading?							

7)Driving at night?							
8)Working with a computer or bank machine (ATM)?							
9)Watching TV?							
15. 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	N/A	
10)Windy conditions?							
11)Places or areas with low humidity (very dry)?							
12)Areas that are air conditioned?							
Thank you!							