RayPRO

ENGLISH

Patient Questionnaire Breakdown

1 Week post-op questionnaire

Question	Answer options
Please rate your satisfaction with the surgeon who performed your eye surgery.	0-10 (not at all satisfied > extremely satisfied)
Please rate your satisfaction with the hospital where you had your eye surgery.	0-10 (not at all satisfied > extremely satisfied)
Did you have confidence in the doctors treating you?	Yes definitely / Yes to some extent / No
How would you rate the quality of our service?	a. Very good
	b. Good
	c. Neither good nor poor
	d. Poor
	e. Very poor
How likely are you to recommend our clinic to friends and family if they needed similar care or treatment?	a. Extremely likely
	b. Likely
	c. Neither likely nor unlikely
	d. Unlikely
	e. Extremely unlikely
	f. Don't know

1 Month post-op questionnaire

Question	Answer options
In the past month, have you felt that your bad eye is affecting or interfering with your vision overall?	a. No, never
	b. Yes, some of the time
	c. Yes, most of the time
	d. Yes, all of the time

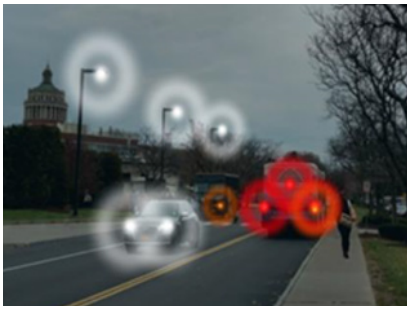
In the past month, how much has your eyesight interfered with your life in general?	a. Not at all
	b. Hardly at all
	c. A little
	d. A fair amount
	e. A lot
	f. An extremely large amount
How would you describe your vision overall in the past month – with both eyes open, wearing glasses or contact lenses if you usually do?	a. Excellent
	b. Very good
	c. Quite good
	d. Average
	e. Quite poor
	f. Very poor
	g. Appalling
In the past month, how often has your eyesight prevented you from doing the things you would like to do?	a. Never
	b. Some of the time
	c. Most of the time
	d. All of the time
In the past month, have you had difficulty reading normal print in books or newspapers because of trouble with your eyesight?	a. No difficulty
	b. Yes, a little difficulty
	c. Yes, some difficulty
	d. Yes, a great deal of difficulty
	e. I cannot read any more because of my eyesight
	f. I cannot read because of other reasons

Please tell us who actually gave the answers to the questions and who wrote them down.	a. I gave all the answers and wrote them down myself
	b. I gave all the answers and someone else wrote them down as I spoke
	c. A friend or relative gave some of the answers on my behalf

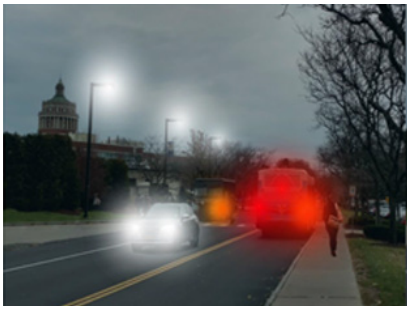
3 Month post-op questionnaire

Question	Answer options
Please rate your satisfaction with the outcome of your eye surgery.	0-10 (not at all satisfied > extremely satisfied)
How often do you wear glasses for distance activities (e.g. driving, watching TV)?	0-10 (always > never)
How often do you wear glasses for mid-distance activities (e.g. using a computer, cooking)?	0-10 (always > never)
How often do you wear glasses for near-distance activities (e.g. reading, using a mobile phone)?	0-10 (always > never)
Do you now have the visual outcomes that you discussed and agreed with your surgeon?	Yes / No / Not sure

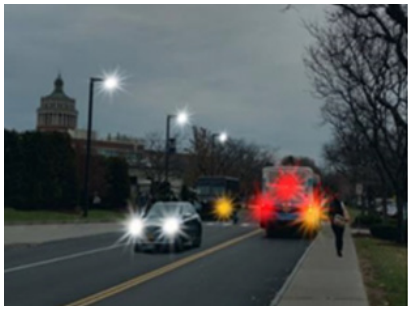
The questions we ask within this section are related to the quality of vision and the level of disturbance you may have experienced. These disturbances could look similar to the following images and affect you while undertaking activities such as shopping, looking at screens or driving.



Halos
Bright rings or circles appearing around light sources.

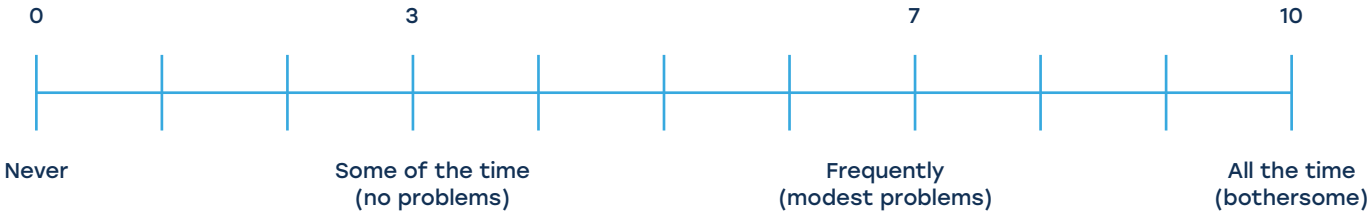


Glare
Intense bright light appearing from a light source.



Starbursts
Lines or rays radiating from a light source.

Do you experience any visual disturbances, such as the ones shown, during the day?	Please rate your level of visual disturbances from 0-10 (never > all the time)
Do you experience any visual disturbances, such as the ones shown, at nighttime?	Please rate your level of visual disturbances from 0-10 (never > all the time)



1 Year post-op questionnaire

Question	Answer options
Please rate your satisfaction with the outcome of your eye surgery.	0-10 (not at all satisfied > extremely satisfied)

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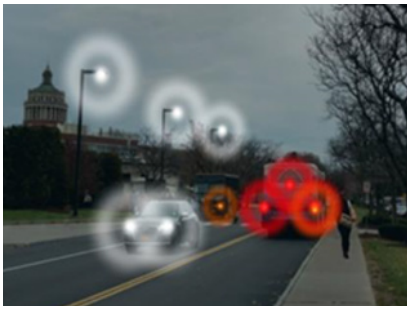

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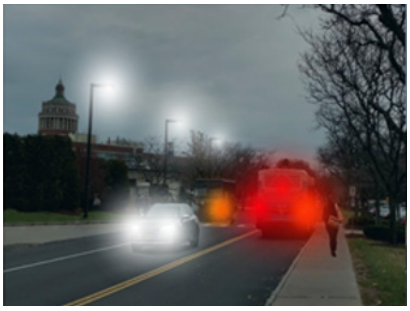

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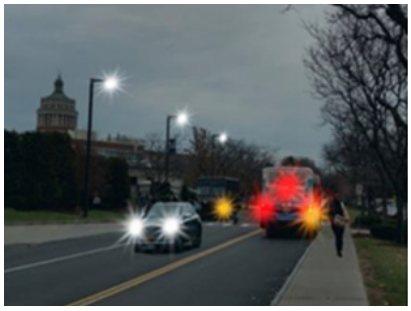

Starbursts
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Do you experience any visual disturbances, such as the ones shown, during the day?	Please rate your level of visual disturbances from 0-10 (never > all the time)
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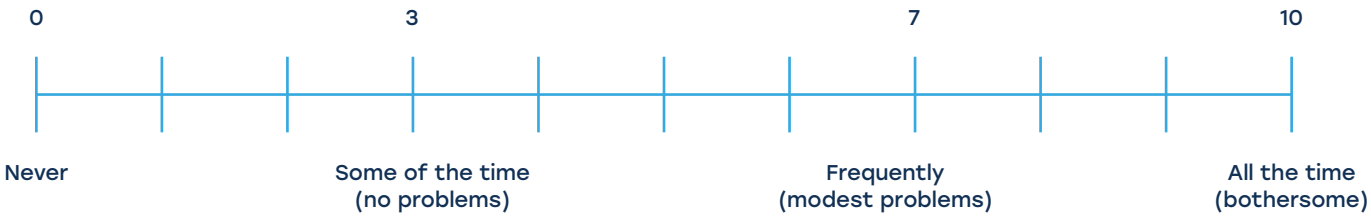

In the last 12 months have you had a laser treatment on your cornea (e.g. LASIK, PRK)?	Yes / No
In the last 12 months have you had a laser treatment inside your eye (e.g. Nd:YAG, capsulotomy)?	Yes / No
In the last 12 months have you had a supplementary intraocular lens (IOL) implanted inside your eye?	Yes / No

2 Year post-op questionnaire

Question	Answer options
In the last 12 months have you had a laser treatment on your cornea (e.g. LASIK, PRK)?	Yes / No
In the last 12 months have you had a laser treatment inside your eye (e.g. Nd:YAG, capsulotomy)?	Yes / No
In the last 12 months have you had a supplementary intraocular lens (IOL) implanted inside your eye?	Yes / No

3 Year post-op questionnaire

Question	Answer options
In the last 12 months have you had a laser treatment on your cornea (e.g. LASIK, PRK)?	Yes / No
In the last 12 months have you had a laser treatment inside your eye (e.g. Nd:YAG, capsulotomy)?	Yes / No
In the last 12 months have you had a supplementary intraocular lens (IOL) implanted inside your eye?	Yes / No