Collagen Crosslinking with Ultraviolet-A in Asymmetric Corneas

Quality of Life Survey Pre-Op

Institution	Subject #	Initials	Date
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1.) In general, would you say your overall health is:	☐ 1 Excellent ☐ 2 Very Good ☐ 3 Good ☐ 4 Fair ☐ 5 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?	☐ 1 Excellent ☐ 2 Good ☐ 3 Fair ☐ 4 Poor ☐ 5 Very poor ☐ 6 Completely blind
3.) How much of the time do you worry about your eyesight?	☐ 1 None of the time ☐ 2 A little of the time ☐ 3 Some of the time ☐ 4 Most of the time ☐ 5 All of the time
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:	☐ 1 None ☐ 2 Mild ☐ 3 Moderate ☐ 4 Severe ☐ 5 Very severe
5.) How much difficulty do you have reading ordinary print in newspapers? Would you say you have:	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
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:	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this

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7.) Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
8.) How much difficulty do you have reading street signs or the names of stores?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
9.) Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
10.) Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
11.) Because of your eyesight, how much difficulty do you have seeing how people react to things you say?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this

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12.) Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
13.) Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
14.) Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Stopped doing this because of your eyesight ☐ 6 Stopped doing this for other reasons or not interested in doing this
15.) Are you currently driving, at least once in awhile?	☐ 1 Yes ☐ 2 No
15.)a. If no, have you never driven a car or have you given up driving?	☐ 1 Never drove ☐ 2 Gave up
15.)b. 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?	☐ 1 Mainly eyesight ☐ 2 Mainly other reasons ☐ 3. Both eyesight and other reasons

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15.)c. If currently driving, how much difficulty do you have driving during the daytime in familiar places? Would you say you have:	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty
16.) How much difficulty do you have driving at night: Would you say you have:	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Have you stopped doing this because of your eyesight ☐ 6 Have you stopped doing this for other reasons or not interested in doing this
16.)a. How much difficulty do you have driving in difficult conditions, such as bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:	☐ 1 No difficulty at all ☐ 2 A little difficulty ☐ 3 Moderate difficulty ☐ 4 Extreme difficulty ☐ 5 Have you stopped doing this because of your eyesight ☐ 6 Have you stopped doing this for other reasons or not interested in doing this
17.) Do you accomplish less that you would like because of your vision:	☐ 1 All of the time ☐ 2 Most of the time ☐ 3 Some of the time ☐ 4 A little of the time ☐ 5 None of the time
18.) Are you limited in how long you can work or do other activities because of your vision?	☐ 1 All of the time ☐ 2 Most of the time ☐ 3 Some of the time ☐ 4 A little of the time ☐ 5 None of the time
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 All of the time ☐ 2 Most of the time ☐ 3 Some of the time ☐ 4 A little of the time ☐ 5 None of the time

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20.) I stay home most of the time because of my eye sight:	☐ 1 Definitely true ☐ 2 Mostly true ☐ 3 Not sure ☐ 4 Mostly false ☐ 5 Definitely false
21.) I feel frustrated a lot of the time because of my eyesight:	☐ 1 Definitely true ☐ 2 Mostly true ☐ 3 Not sure ☐ 4 Mostly false ☐ 5 Definitely false
22.) I have much less control over what I do, because of my eyesight:	☐ 1 Definitely true ☐ 2 Mostly true ☐ 3 Not sure ☐ 4 Mostly false ☐ 5 Definitely false
23.) Because of my eyesight, I have to rely too much on what other people tell me:	☐ 1 Definitely true ☐ 2 Mostly true ☐ 3 Not sure ☐ 4 Mostly false ☐ 5 Definitely false
24.) I need a lot of help from others because of my eyesight:	☐ 1 Definitely true ☐ 2 Mostly true ☐ 3 Not sure ☐ 4 Mostly false ☐ 5 Definitely false
25.) I worry about doing things that will embarrass myself or others, because of my eyesight:	☐ 1 Definitely true ☐ 2 Mostly true ☐ 3 Not sure ☐ 4 Mostly false ☐ 5 Definitely false

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CXL Comfort Survey Pre-Op

Institution **Subject #** **Initials** **Date**

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If you had both eyes treated on the same day, which eye is seeing better?

☐ Right Eye ☐ No Difference ☐ Left Eye ☐ I had only One Eye treated this week

	Right Eye	Left Eye
A.) How much **Pain** are you experiencing in each eye? 0=no pain, 10=worst pain of my life	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
B.) How much **Burning** are you experiencing in each eye? 0=No burning, 10=Most Severe	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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CXL Comfort Survey Pre-Op

Institution **Subject #** **Initials** **Date** ☐☐ / ☐☐ / ☐☐

	Right Eye	Left Eye
C.) How much **Sensitivity to light** are you experiencing in each eye? 0=No Sensitivity to light, 10=Most Severe amount of sensitivity to light	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
D.) How much **Scratchiness/grittiness** are you experiencing in each eye? 0=No Scratchiness/grittiness, 10=Most Severe amount of Scratchiness/grittiness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10