

Production - Release 2.0

LASIK

[\$sitecode]

User:

Post-Operative Questionnaire (POQ)

Web Version: 1.0; 1.00; 06-02-15

1. Where are you taking this questionnaire?

- ☐ Home
- ☐ Doctor's office
- ☐ Other location

2. In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

INSTRUCTIONS: When you answer the question below, think about the vision correction you normally use, including glasses, contact lenses, a magnifier, or nothing at all.

3. How often do you worry about your eyesight or vision?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Sometimes
- ☐ All the time

4. How often do you notice or think about your eyesight or vision?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Sometimes

☐ All the time

5. At this time, how clear is your vision using the correction you normally use, including glasses, contact lenses, a magnifier, or nothing at all?

☐ Perfectly clear

☐ Pretty clear

☐ Somewhat clear

☐ Not clear at all

6. Have you ever driven a car?

☐ Yes

☐ No

7. Do you currently drive?

☐ Yes

☐ No

8. If you gave up driving, was that mainly because of your vision, mainly for some other reason, or because of both your vision and other reasons?

☐ Mainly vision

☐ Mainly other reasons

☐ Both vision and other reasons

INSTRUCTIONS: When you answer the question below, think about your vision with the vision correction you normally use, including glasses, contact lenses, a magnifier, or nothing at all.

9. Because of your vision, how much difficulty do you have driving during the daytime in familiar places? Would you say you have:

☐ No difficulty at all

☐ A little difficulty

☐ Moderate difficulty

☐ A lot of difficulty

☐ Never drive during the daytime because of vision

☐ Never drive during the daytime for other reasons

10. Because of your vision, how much difficulty do you have driving at night?

☐ No difficulty at all

☐ A little difficulty

☐ Moderate difficulty

- ☐ A lot of difficulty
- ☐ Never drive at night because of vision
- ☐ Never drive at night for other reasons

11. Because of your vision, how much difficulty do you have driving in difficult conditions, such as bad weather, during rush hour, on the freeway, or in city traffic?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ Never drive in these conditions because of vision
- ☐ Never drive in these conditions for other reasons

12. How much difficulty do you have seeing things off to the side, like cars coming out of driveways or side streets or people coming out of doorways?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty

13. Because of your vision, how much difficulty do you have with your daily activities?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty

14. Because of your vision, how much difficulty do you have taking part in active sports or other outdoor activities that you enjoy (like hiking, swimming, aerobics, team sports, or jogging)?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ Never try to do these activities because of vision
- ☐ Never do these activities for other reasons

15. Because of your vision, do you take part less than you would like in active sports or other outdoor activities (like hiking, swimming, aerobics, team sports, or jogging)?

☐ Yes

☐ No

16. Are there any recreational or sports activities that you don't do because of your vision or the type of vision correction you have?

☐ Yes

☐ No

17. You have noted that you have difficulty with your daily activities because of your vision. Please list those activities with which you have difficulty (e.g., watching television, using automated teller machines (ATM), etc.).

INSTRUCTIONS: When you answer the question below, think about the vision correction you normally use, including glasses, contact lenses, a magnifier, or nothing at all.

18. How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, fixing things around the house, sewing, using hand tools, or working with a computer?

☐ No difficulty at all

☐ A little difficulty

☐ Moderate difficulty

☐ A lot of difficulty

☐ Never try to do these activities because of vision

☐ Never do these activities for other reasons

19. How much difficulty do you have reading ordinary print in newspapers?

☐ No difficulty at all

☐ A little difficulty

☐ Moderate difficulty

☐ A lot of difficulty

☐ Never try to do this because of vision

☐ Never try to do this for other reasons

20. How much difficulty do you have reading small print in a telephone book, on a medicine bottle, or on legal forms?

☐ No difficulty at all

☐ A little difficulty

☐ Moderate difficulty

- ☐ A lot of difficulty
- ☐ Never try to do these activities because of vision
- ☐ Never do these activities for other reasons

21. Are there daily activities that you would like to do, but don't do, because of your vision or the type of vision correction you have?

- ☐ Yes, many
- ☐ Yes, one or a few
- ☐ No

22. How much difficulty do you have judging distances, like walking down stairs or parking a car?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty

23. How much difficulty do you have getting used to the dark when you move from a lighted area into a dark place, like walking into a dark movie theater?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty

24. How much difficulty do you have seeing because of changes in the clarity of your vision during the course of the day?

- ☐ Don't have changes in the clarity of my vision
- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty

25. How often are you bothered by changes in the clarity of your vision over the course of the day?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Sometimes
- ☐ All the time

26. How often when you are around bright lights at night do you see starbursts or haloes that bother you or make it difficult to see.

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

27. Have you experienced glare in the last 7 days?

- ☐ Yes
- ☐ No

27a. How bothersome has it been?

- ☐ Very
- ☐ Somewhat
- ☐ A little
- ☐ Not at all

28. Have you experienced distorted vision in the last 7 days?

- ☐ Yes
- ☐ No

28a. How bothersome has it been?

- ☐ Very
- ☐ Somewhat
- ☐ A little
- ☐ Not at all

29. Have you experienced blurry vision in the last 7 days?

- ☐ Yes
- ☐ No

29a. How bothersome has it been?

- ☐ Very
- ☐ Somewhat
- ☐ A little
- ☐ Not at all

30. Have you experienced trouble seeing in the last 7 days?

☐ Yes

☐ No

30a. How bothersome has it been?

☐ Very

☐ Somewhat

☐ A little

☐ Not at all

INSTRUCTIONS: The following question asks about the effect on any problems with your eyes on your ability to perform your regular tasks.

31. Because of your LASIK surgery, do you now have any problems or limitations that did not exist prior to LASIK surgery?

☐ Yes

☐ No

32. What problems or limitations do you have because of your LASIK surgery?

33. Have these problems or limitations affected the quality of your life?

☐ Yes, the quality of my life has gotten a lot worse

☐ Yes, the quality of my life has gotten a little bit worse

☐ No, the quality of my life has not been affected

☐ Yes, the quality of my life has gotten a little bit better

☐ Yes, the quality of my life has gotten a lot better

34. In general, how satisfied or dissatisfied are you with your present vision?

☐ Completely satisfied

☐ Very satisfied

☐ Somewhat satisfied

☐ Somewhat dissatisfied

☐ Very dissatisfied

☐ Completely dissatisfied

35. Are you currently employed (working for pay)?

☐ Yes

☐ No

INSTRUCTIONS: The following question asks about the effect of any problem with your eyes on your ability to work and perform regular activities during the past seven days, not including today.

36. During the past seven days, how many hours did you miss from work because of *any eye problems*?

Include hours your missed on sick days, time you went in late, left early, etc., because of your eye problems. Do not include time you missed to participate in this study.

HOURS

37. 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

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

HOURS

39. During the past seven days, how much did eye problems 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 eye problems affected your work only a little, choose a low number. Choose a high number if eye problems affected your work a great deal.

Consider only how much eye problems affected productivity while you were working.

Eye problem(s) had no effect on my work	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Eye problem(s) completely prevented me from working
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SELECT A NUMBER

40. During the past seven days, how much did eye problems 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 eye problems affected your activities only a little, choose a low number. Choose a high number if eye problems affected your activities a great deal.

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

Eye problem(s) had no effect on my daily activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Eye problem(s) completely prevented me from doing my regular activities
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SELECT A NUMBER

41. In a typical day:

(please select all that apply)

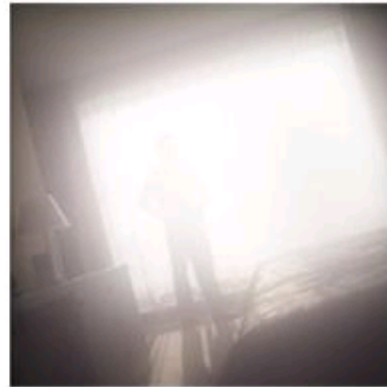
- ☐ I do not use glasses or contact lenses
- ☐ I use glasses to correct my vision for distance
- ☐ I use glasses to correct my vision for reading
- ☐ I use soft contact lenses to correct my vision for distance
- ☐ I use soft contact lenses to correct my vision for reading
- ☐ I use hard (rigid gas permeable) contact lenses to correct my vision for distance
- ☐ I use hard (rigid gas permeable) contact lenses to correct my vision for reading

The next set of questions will reference the following images and their labels.

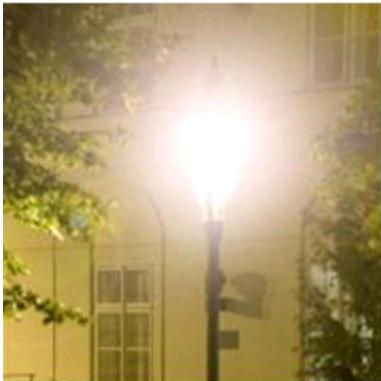
Double image



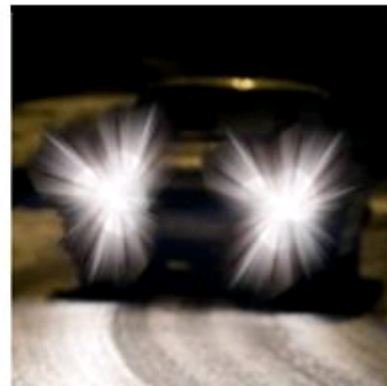
Glare



Halo

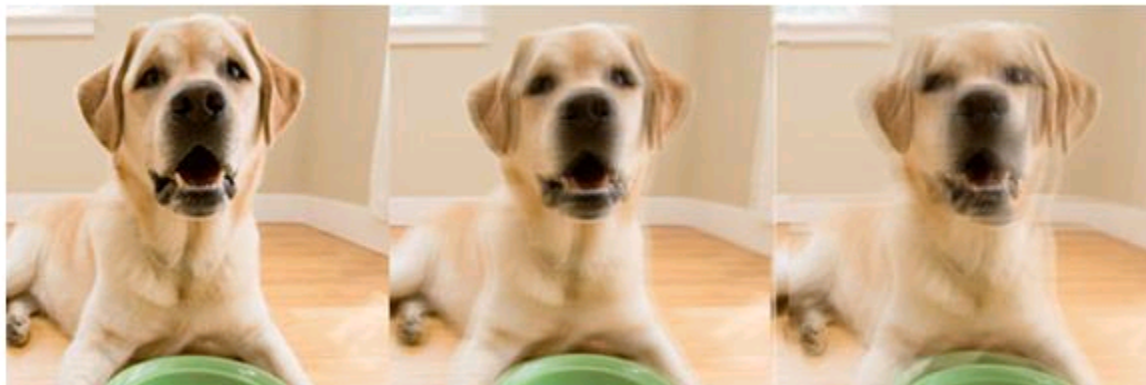


Starburst



INSTRUCTIONS: The next few questions are about double images, which some people call "ghost" or "shadow" images. By double images, we mean seeing a *distorted or blurry visual image*, such as the images shown below. These images may not represent exactly what you see and your symptoms may be more or less severe than what is shown.

No double image —————> Severe double image



42. In the last 7 days, have you seen any **double images**?

- ☐ Yes, but ONLY when NOT wearing glasses or contact lenses
- ☐ Yes, but ONLY when wearing glasses or contact lenses
- ☐ Yes, when wearing AND when not wearing glasses or contact lenses
- ☐ No, not at all

43a. In the last 7 days, how often have you seen **double images** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

43b. In the last 7 days, how often have you seen **double images** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ I always use glasses or contact lenses

44a. In the last 7 days, how bothersome have the **double images** been when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome

44b. In the last 7 days, how bothersome have the **double images** been when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome
- ☐ I always use glasses or contact lenses

45a. In the last 7 days, how much difficulty have you had doing your usual activities because you see **double images** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities

45b. In the last 7 days, how much difficulty have you had doing your usual activities because you see **double images** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities
- ☐ I always use glasses or contact lenses

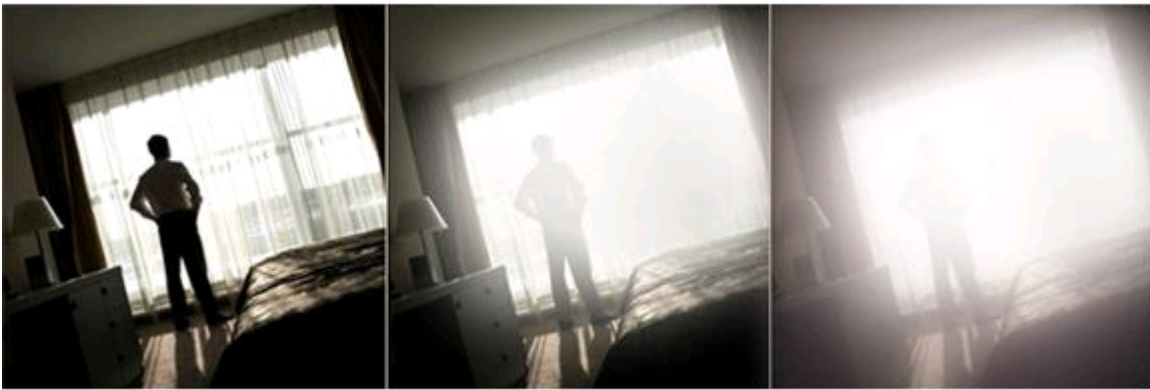
46. When you use your best vision correction (glasses or contact lenses) do the **double images** you see:

- ☐ I do not use glasses or contact lenses

- ☐ Go away completely
- ☐ Go away mostly
- ☐ Go away a little
- ☐ Not change
- ☐ Get a little worse
- ☐ Get a lot worse

INSTRUCTIONS: The next few questions are about glare. By glare, we mean *difficulty seeing well when there are bright lights* like headlights or sunlight, such as shown in the images below. These images may not represent exactly what you see and your symptoms may be more or less severe than what is shown.

No glare → Severe glare



47. In the last 7 days, have you noticed any **glare**?

- ☐ Yes, but ONLY when NOT wearing glasses or contact lenses
- ☐ Yes, but ONLY when wearing glasses or contact lenses
- ☐ Yes, when wearing AND when not wearing glasses or contact lenses
- ☐ No, not at all

48a. In the last 7 days, how often have you noticed **glare** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

48b. In the last 7 days, how often have you noticed **glare** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ I always use glasses or contact lenses

49a. In the last 7 days, how bothersome has the **glare** been when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome

49b. In the last 7 days, how bothersome has the **glare** been when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome
- ☐ I always use glasses or contact lenses

50a. In the last 7 days, how much difficulty have you had doing your usual activities because you noticed **glare** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities

50b. In the last 7 days, how much difficulty have you had doing your usual activities because you notice **glare** when you are NOT wearing any vision correction (glasses or contact lenses)?

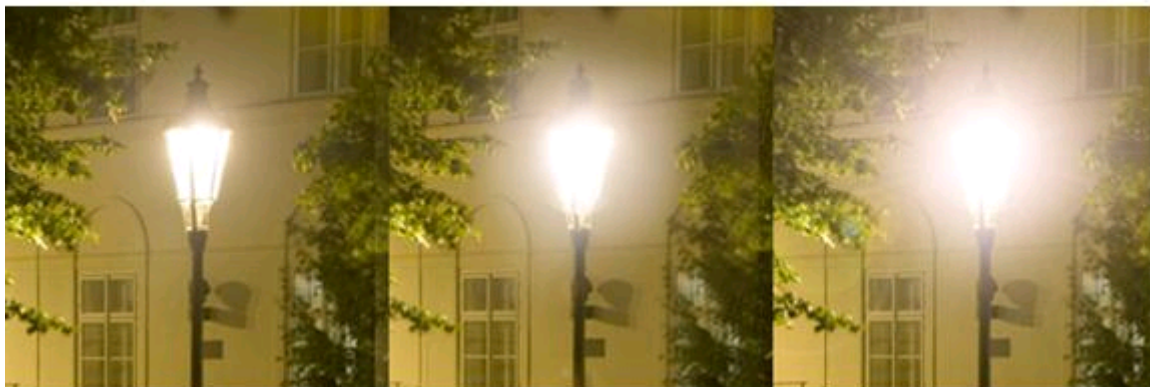
- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities
- ☐ I always use glasses or contact lenses

51. When you use your best vision correction (glasses or contact lenses) does the **glare** you notice:

- ☐ I do not use glasses or contact lenses
- ☐ Go away completely
- ☐ Go away mostly
- ☐ Go away a little
- ☐ Not change
- ☐ Get a little worse
- ☐ Get a lot worse

INSTRUCTIONS: The next few questions are about halos. By halos, we mean *seeing a fuzzy cloud of light around lighted objects*, such as the ones shown in the images below. These images may not represent exactly what you see and your symptoms may be more or less severe than what is shown.

No halos —————→ Severe halos



52. In the last 7 days, have you seen any **halos**?

- ☐ Yes, but ONLY when NOT wearing glasses or contact lenses
- ☐ Yes, but ONLY when wearing glasses or contact lenses
- ☐ Yes, when wearing AND when not wearing glasses or contact lenses
- ☐ No, not at all

53a. In the last 7 days, how often have you seen **halos** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

53b. In the last 7 days, how often have you seen **halos** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ I always use glasses or contact lenses

54a. In the last 7 days, how bothersome have the **halos** been when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome

54b. In the last 7 days, how bothersome have the **halos** been when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome
- ☐ I always use glasses or contact lenses

55a. In the last 7 days, how much difficulty have you had doing your usual activities because you see **halos** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities

55b. In the last 7 days, how much difficulty have you had doing your usual activities because you see **halos** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities
- ☐ I always use glasses or contact lenses

56. When you use your best vision correction (glasses or contact lenses) do the **halos** you see:

- ☐ I do not use glasses or contact lenses
- ☐ Go away completely
- ☐ Go away mostly
- ☐ Go away a little
- ☐ Not change
- ☐ Get a little worse
- ☐ Get a lot worse

INSTRUCTIONS: The next few questions are about starbursts. By starbursts, we mean *seeing rays of light coming out from lighted objects*, such as in the car headlights in the images below. These images may not represent exactly what you see and your symptoms may be more or less severe than what is shown.

No starbursts → Severe starbursts



57. In the last 7 days, have you seen any **starbursts**?

- ☐ Yes, but ONLY when NOT wearing glasses or contact lenses
- ☐ Yes, but ONLY when wearing glasses or contact lenses
- ☐ Yes, when wearing AND when not wearing glasses or contact lenses
- ☐ No, not at all

58a. In the last 7 days, how often have you seen **starbursts** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

58b. In the last 7 days, how often have you seen **starbursts** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ I always use glasses or contact lenses

59a. In the last 7 days, how bothersome have the **starbursts** been when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome

59b. In the last 7 days, how bothersome have the **starbursts** been when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ Extremely bothersome
- ☐ Very bothersome
- ☐ Somewhat bothersome
- ☐ A little bothersome
- ☐ Not at all bothersome
- ☐ I always use glasses or contact lenses

60a. In the last 7 days, how much difficulty have you had doing your usual activities because you see **starbursts** when you are wearing your best vision correction (glasses or contact lenses)?

- ☐ I do not use glasses or contact lenses
- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities

60b. In the last 7 days, how much difficulty have you had doing your usual activities because you see **starbursts** when you are NOT wearing any vision correction (glasses or contact lenses)?

- ☐ No difficulty at all
- ☐ Very little difficulty
- ☐ Moderate difficulty
- ☐ A lot of difficulty
- ☐ So much difficulty that I can no longer do some of my usual activities
- ☐ I always use glasses or contact lenses

61. When you use your best vision correction (glasses or contact lenses) do the **starbursts** you see:

- ☐ I do not use glasses or contact lenses
- ☐ Go away completely
- ☐ Go away mostly
- ☐ Go away a little
- ☐ Not change
- ☐ Get a little worse
- ☐ Get a lot worse

INSTRUCTIONS: During the last 7 days, how often have you experienced:

62. Eyes that are sensitive to light?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

63. Eyes that feel gritty?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

64. Painful or sore eyes?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

65. Blurred vision?

- ☐ None of the time
- ☐ Some of the time

- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

66. Poor vision?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

INSTRUCTIONS: During the last 7 days, how often have your eyes felt uncomfortable in:

67. Windy conditions?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

68. Places or areas with low humidity (very dry)?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

69. Areas that are air conditioned?

- ☐ None of the time
- ☐ Some of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

70. Did your surgeon or health provider from this surgeon's office explain what to expect during your recovery period from LASIK surgery?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

71. Currently, how satisfied or dissatisfied are you with the result of your LASIK surgery?

- ☐ Completely satisfied
- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied
- ☐ Completely dissatisfied

72. Currently, how satisfied or dissatisfied are you with how long it took to see improvement in your vision after LASIK surgery?

- ☐ Completely satisfied
- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied
- ☐ Completely dissatisfied
- ☐ Never had any improvement in my vision after LASIK surgery

73. Currently, how satisfied or dissatisfied are you with how long it took to see improvement in your post-operative symptoms of discomfort after LASIK surgery?

- ☐ Completely satisfied
- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied
- ☐ Completely dissatisfied
- ☐ Never had any post-operative symptoms of discomfort after LASIK surgery

74. How well do you feel you understood the risks and benefits of the LASIK procedure before treatment?

- ☐ Completely understood

- ☐ Somewhat understood
- ☐ Somewhat misunderstood
- ☐ Completely misunderstood

75. When you are not wearing glasses or contact lenses, is your distance vision now as good as you anticipated it would be after LASIK surgery?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

76. Are you currently wearing glasses or contact lenses to see things in the distance?

- ☐ No, none of the time
- ☐ Yes, some of the time
- ☐ Yes, most of the time
- ☐ Yes, all of the time

77. Did you achieve the goals you had for LASIK surgery?

- ☐ Yes, fully achieved
- ☐ Yes, partially achieved
- ☐ No

78. How happy or unhappy are you that you had LASIK surgery?

- ☐ Completely happy
- ☐ Very happy
- ☐ Somewhat happy
- ☐ Somewhat unhappy
- ☐ Very unhappy
- ☐ Completely unhappy

79. If you could do it all over again, would you decide to have LASIK performed?

- ☐ Yes, I would decide to have it again, because of my result.
- ☐ Yes, I would decide to have it again, despite my result.
- ☐ No, I would not decide to have it again, because of my result.
- ☐ No, I would not decide to have it again, despite my result.

80. Would you recommend LASIK surgery to a friend or family member?

- ☐ Yes, I would recommend it because of my result.

- ☐ Yes, I would recommend it despite my result.
- ☐ No, I would not recommend it because of my result.
- ☐ No, I would not recommend it despite my result.

81. Why would you not have LASIK done again or not recommend it to a friend or family member?

(please select all that apply)

- ☐ Did not like the facility
- ☐ Did not like the surgeon
- ☐ Did not like the staff
- ☐ Did not like the procedure
- ☐ Did not like the results
- ☐ Other

82. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

83. Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

84. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

85. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days

☐ Nearly every day