The Quality of Life Impact of Refractive Correction (QIRC)

Welcome to QIRC, a questionnaire designed to measure the quality of life of people who require an optical correction (spectacles, contact lenses or refractive surgery).

If you wear SPECTACLES AND/OR CONTACT LENSES during all your waking hours, please complete the appropriate section on this page.

If you only wear spectacles and/or contact lenses for part of your waking hours, go to the next page.

Ordinary sunglasses DO NOT count as spectacles.

i) Spectacles only. Worn full-time.	

How old are your current spectacles? _____ Go to example 1 below

ii) Contact lenses only. Worn full-time.	

How old are your current contact lenses? _____ Go to example 1 below

iii) Both spectacles and contact lenses worn. Either worn for all waking hours.	

How old are your current spectacles? _____

How old are your current contact lenses? _____ Go to example 2 below

Example 1: How much difficulty do you have reading very small print?

Not applicable	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity
		✓			

Example 2: How much difficulty do you have reading for long periods?

Not applicable	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity
	C	***S***			

Go to the questionnaire.

If you wear SPECTACLES AND/OR CONTACT LENSES on a part-time basis, please complete the appropriate section on this page.

a) Tick and/or complete the appropriate boxes regarding your current optical correction.
Ordinary sunglasses DO NOT count as spectacles.

i) Spectacles only. Worn part-time.	

How many hours per day do you wear them? _____ hours/day

ii) Contact lenses only. Worn part-time.	

How many hours per day do you wear them? _____ hours/day

iii) Both spectacles and contact lenses. Worn part-time.	

Spectacles	Hours/day
Contact lenses	Hours/day

b)
How old are your current spectacles? _____ Answer N/A if this
How old are your current contact lenses? _____ does not apply to you

Instructions on how to complete this questionnaire.

If you wear spectacles and/or contact lenses on a part-time basis, use:	**S:** as your answer for when wearing spectacles **C:** as your answer for when wearing contact lenses **N:** as your answer for when not wearing spectacles or contact lenses

Example for a part-time spectacle wearer:

How much difficulty do you have reading for long periods?

Not applicable	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity
		S		***N***	

Example for a part-time contact lens wearer:

How much difficulty do you have reading for long periods?

Not applicable	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity
		C	***N***		

Go to the questionnaire.

Post-op instructions

If you have had REFRACTIVE SURGERY (LASIK, PRK ETC), please answer the questions on this page and read the instructions on how to complete the rest of the questionnaire.

- How long is it since you had refractive surgery? _____

Please indicate which of the following two groups you belong to see how to answer the questionnaire.

a) If you do not wear spectacles or contact lenses SINCE your refractive surgery (LASIK, PRK etc.), please tick the appropriate box for each of the questions as in the example below.

Example: How much difficulty do you have reading very small print?

Not applicable	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity
		✓			

Go to the questionnaire.

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b) If you occasionally still wear spectacles and/or contact lenses SINCE your refractive surgery, please estimate how many hours per day you wear them on average. Ordinary sunglasses DO NOT count as spectacles.

Spectacles	Days/week	Hours/day
Contact lenses	Days/week	Hours/day

How old are your current contact lenses? _____

How old are your current spectacles? _____

Please answer the questions on pages 2-5 depending on whether you were wearing the correction or not, as in the example below:

S: as your answer for when wearing spectacles.
C: as your answer for when wearing contact lenses.
N: as your answer when not wearing contact lenses or spectacles.

Example: How much difficulty do you have reading for long periods?

Not applicable	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity
	S C	***N***			

Go to the questionnaire.

Questionnaire

QIRC

Pre-op version: Please fill out the questions below regarding your current spectacles or contact lenses.

Post-op version: Please respond to the following questions for how you are **NOW**, not how you were before refractive surgery.

1. How much difficulty do you have driving in glare conditions?

Don't drive for reasons other than my vision	None at all	A little bit	A moderate amount	A lot	So much that I can't do this activity

2. During the past month, how often have you experienced your eyes feeling tired or strained?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

3. How much trouble is not being able to use off-the-shelf (non prescription) sunglasses?

Don't know / Not applicable	None	A little bit	A moderate amount	Quite a lot	Extreme

4. How much trouble is having to think about your spectacles or contact lenses or your eyes after refractive surgery before doing things; e.g. travelling, sport, going swimming?

Don't know / Not applicable	None	A little bit	A moderate amount	Quite a lot	Extreme

5. How much trouble is not being able to see when you wake up; e.g. to go to the bathroom, look after a baby, see alarm clock?

Don't know / Not applicable	None	A little bit	A moderate amount	Quite a lot	Extreme

6. How much trouble is not being able to see when you are on the beach or swimming in the sea or pool, because you do these activities without spectacles or contact lenses?

Don't know / Not applicable	None	A little bit	A moderate amount	Quite a lot	Extreme

Questionnaire

7. How much trouble are your spectacles or contact lenses when you wear them when using a gym / doing keep-fit classes / circuit training etc?

Don't know / Not applicable	None	A little bit	A moderate amount	Quite a lot	Extreme

8. How concerned are you about the initial and ongoing cost to buy your refractive surgery/ current spectacles and/or contact lenses/?

Don't know / Not applicable	Not at all	A little bit	A moderate amount	Quite a lot	Extremely

9. How concerned are you about the cost of unscheduled maintenance of your refractive surgery/ spectacles/ contact lenses; e.g. breakage, loss, new eye problems?

Don't know / Not applicable	Not at all	A little bit	A moderate amount	Quite a lot	Extremely

10. How concerned are you about having to increasingly rely on your spectacles or contact lenses since you started to wear them?

Don't know / Not applicable	Not at all	A little bit	A moderate amount	Quite a lot	Extremely

11. How concerned are you about your vision being not as good as it could be?

Don't know / Not applicable	Not at all	A little bit	A moderate amount	Quite a lot	Extremely

12. How concerned are you about medical complications from your choice of optical correction (refractive surgery, spectacles and/or contact lenses)?

Don't know / Not applicable	Not at all	A little bit	A moderate amount	Quite a lot	Extremely

13. How concerned are you about eye protection from ultraviolet (UV) radiation?

Don't know / Not applicable	Not at all	A little bit	A moderate amount	Quite a lot	Extremely

Questionnaire

Pre-op version: *We are now interested in the effect that your spectacles and/or contact lenses have had on the way you have been feeling. The effect on your feelings may be obvious (e.g., you may feel that you look better in your new spectacles) or it may be indirect (e.g., you may feel more confident since wearing contact lenses because you feel that you look better).*

Post-op version: Please respond to the following questions for how you are **NOW**, not how you were before refractive surgery.

We are now interested in the effect that your optical correction (refractive surgery, plus possible spectacle and/or contact lenses) have had on the way you have been feeling. The effect on your feelings may be obvious (e.g., you may feel that you look better without spectacles) or it may be indirect (e.g., you may feel more confident after refractive surgery because you feel that you look better).

14. During the past month, how much of the time have you felt that you have looked your best?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

15. During the past month, how much of the time have you felt that you think others see you the way you would like them to (e.g. intelligent, sophisticated, successful, cool, etc)?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

16. During the past month, how much of the time have you felt complimented / flattered?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

17. During the past month, how much of the time have you felt confident?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

18. During the past month, how much of the time have you felt happy?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

19. During the past month, how much of the time have you felt able to do the things you want to do?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always

20. During the past month, how much of the time have you felt eager to try new things?

Don't know / Not applicable	Never	Occasionally	Fairly often	Very often	Always