

1. Sex

- a) Woman
- b) Man

2. Age

- a) <20 years
- b) 20-25 years old
- c) 26-30 years old
- d) >30 years

3. Place of residence

- a) City
- b) Village

4. Field of study

- a) Medical
- b) Other than medical

5. Name of the field of study /Year of study

- a) 1 year of first-cycle / uniform master's studies
- b) 2nd year of first-cycle / long-cycle Master's studies
- c) 3rd year of first-cycle / long-cycle Master's studies
- d) 1 year of second-cycle studies / 4-year of uniform master's studies
- e) 2nd year of second-cycle studies / 5th year of uniform master's studies
- f) 3rd year of second-cycle studies / 6th year of uniform master's studies

6. Do you have a refractive error?

- a) lack
- b) myopia
- c) hyperopia
- d) astigmatism

7. Have you had surgery to correct your refractive error in the past?

- a) YES
- b) NO

8. Do you use contact lenses?

- a) YES
- b) NO

9. If you wear contact lenses, for how long?

- a) year
- b) 2-3 years
- c) >3 years

10.If you wear contact lenses, do you tolerate them well?

- a) YES
- b) NO

11.Do you have any eye diseases (cataracts, glaucoma, other)?

- a) YES
- b) NO

12.Have you ever had eye injuries?

- a) YES
- b) NO

13.Do you have the following diseases?

- a) hypertension
- b) heart diseases
- c) depression
- d) other mental illnesses
- e) thyroid disease
- f) diabetes
- g) allergy
- h) rosacea
- i) autoimmune diseases (RA, lupus, systemic sclerosis, AS, Sjogren's syndrome, others)
- j) vitamin deficiency AND
- k) neurological diseases (MS, neuropathies)
- l) amyloidosis
- m) sarcoidosis
- n) hormonal disorders

14.Which of the following drugs are you taking on a regular basis?

- a) β -blockers
- b) diuretics
- c) psychotrop medicines
- d) antihistamines
- e) painkillers
- f) glucocorticoids (GCS)
- g) anabolic steroids
- h) oral contraceptives
- i) other hormonal drugs

15.Do you use tobacco products on a regular, daily basis?

- a) YES
- b) NO

16.Do you have any other addictions? If so, please enter which ones.

17.Have you had a Covid-19 infection?

- a) YES
- b) NO

18. Have you been vaccinated against Covid-19?

- a) Yes, full dose (two doses of a two-dose vaccine or one single-dose vaccine)
- b) Yes, with a partial dose (one dose of a two-dose vaccine)
- c) Yes, full dose and third booster
- d) No

19. How would you rate your overall stress level?

- a) 0 Lack of stress
- b) 1
- c) 2
- d) 3
- e) 4
- f) 5 Maximum stress

Ocular Surface Disease Index (OSDI)

Have you experienced any of the following during the last week:

20. Eyes that are sensitive to light?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

21. Eyes that feel gritty?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

22. Painful or sore eyes?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

23. Blurred vision?

- a) All of the time
- b) Most of the time

- c) Half of the time
- d) Some of the time
- e) None of the time

24. Poor vision?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

Have problems with your eyes limited you in performing any of the following during the last week:

25. Reading?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

26. Driving at night?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

27. Working with a computer or bank machine ?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

28. Watching TV?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

Have your eyes felt uncomfortable in any of the following situations during the last week:

29. Windy conditions?

- a) All of the time
- b) Most of the time

- c) Half of the time
- d) Some of the time
- e) None of the time

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

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

31. Areas that are air conditioned?

- a) All of the time
- b) Most of the time
- c) Half of the time
- d) Some of the time
- e) None of the time

DEQ-5

32. During a typical day in the past month, how often did your eyes feel discomfort?

- a) never
- b) rarely
- c) sometimes
- d) frequently
- e) constantly

33. When your eyes feel discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

- a) 0 - never have it
- b) 1
- c) 2
- d) 3
- e) 4
- f) 5 - very intense

34. During a typical day in the past month, how often did your eyes feel dry?

- a) never
- b) rarely
- c) sometimes
- d) frequently
- e) constantly

35. When your eyes felt dry, how intense was this feeling of dryness at the end of the day, within two hours of going to bed?

- a) 0 - never have it
- b) 1
- c) 2
- d) 3
- e) 4
- f) 5 - very intense

36. During a typical day in the past month, how often did your eyes look or feel excessively watery?

- a) never
- b) rarely
- c) sometimes
- d) frequently
- e) constantly

37. How many hours a day do you spend in close proximity to the screen of an electronic device, e.g. mobile phone, computer, tablet, reader (not taking into account a TV set)?

- a) <4
- b) 4-8
- c) >8

38. How many hours a day do you spend in front of the screen of an electronic device (not taking into account a TV set), without taking breaks?

- a) <1
- b) 1-2
- c) 3-4
- d) >4

39. How many hours a day do you spend outdoors?

- a) <1
- b) 1-4
- c) >4

40. How many hours a day do you spend in air-conditioned interiors?

- a) <1
- b) 1-4
- c) >4