Supplementary material: Structured patient survey

1) Does light generally cause you discomfort? (please circle) **YES** / **NO**

2) If YES, on a scale of 1 to 100 (with 0 being no discomfort at all, and 100 being unbearable discomfort) how would you rate that discomfort? (please state below)

3) Do bright lights cause you more problems with: (please tick one) ____ Discomfort/pain? **OR** ______ Increased difficulty in seeing?

4) Do you wear any aids (e.g. sunglasses/ tinted spectacles / a cap) to decrease any light sensitivity? (please circle) **YES** / **NO**

5) If YES, where do you wear these aids? (please tick) _____Outdoors _____Indoors _____Both

6) Also if YES, does the need for any such aids ever make you feel overly self-conscious or embarrassed in social situations? (please circle) **YES** / **NO**

7) Does any light sensitivity affect your ability to carry out your normal activities of daily living? (please circle) **YES** / **NO**

8) If YES, which ONE of the following best describes your current ability to carry out your normal activities of daily living in relation to any light sensitivity? (please tick one)

   _____Aware of light sensitivity, but no limitation in my ability to carry out my normal activities of daily living

   _____Mild to moderate limitation in my ability to carry out my normal activities of daily living

   _____Marked limitation in my ability to carry out my normal activities of daily living
9) If light sensitivity has limited your ability to carry out any activities in your daily life, what has it limited you from doing? (please write below)

10) If you could improve ONE aspect of your vision, which ONE of these would you choose? (please tick one)

_____ Improve vision for detail/reading (visual acuity)

_____ Enable color vision

_____ Reduce sensitivity to light

_____ Reduce any involuntary movement of the eyes

_____ Other - please state here:

11) Which ONE of the following best describes the effect that any light sensitivity has had on your ability to do any kind of work, or your choice of work, if any? (please tick one)

_____ No limitation

_____ Mild to moderate limitation because of light sensitivity

_____ Marked limitation because of light sensitivity

12) Do you feel that any light sensitivity you might have has impacted on your employment prospects? (please circle) YES / NO If YES, please tell us how? (please write here):

13) If there is anything about the effect that light sensitivity might have on your life that we have not covered in this survey, then please tell us here: