**Figure S1. Dry eye questionnaire**

Name: 
Date of birth: ___ / ___ / ___ (DD/MM/YYYY)

Gender: Male □  female □

Date of visit: 
Name of investigator(s):

Ethnicity: Asian □  African □  Caucasian □  mixed □

**General health and ocular status**

Do you have diabetes:  yes □  No □
If yes please specify the type and duration:

Have you worn contact lenses in the past?  Yes □  No □

**Eye Dryness questions**

Q1. Do you have one of the following dry eye symptoms:
   Eye discomfort □
   Eye Redness □
   Eye Itching □
   Gritty or sandy sensation in your eye □
   Watery or teary eye □
   Burning sensation in your eye □

Q2. During a typical day in the past week, how often did your eyes feel dry?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Q3. When your eyes felt dry and how intense was this feeling of dryness?

   a. Within the first two hours of getting up in the morning?

      | Never have it | Not at all intense | Very intense |
      | 0            | 1                   | 2           | 3       | 4       | 5       |

   b. At the end of the day, within two hours of going to bed?

      | Never have it | Not at all intense | Very intense |
      | 0            | 1                   | 2           | 3       | 4       | 5       |

Q4. When your eyes felt dry, how much did the dryness bother you?

      | Never have it | Not at all intense | Very intense |
      | 0            | 1                   | 2           | 3       | 4       | 5       |