Patient/Subject #:______________

Date:__/___/____Time:________

CONTACT LENS QUESTIONNAIRE-8 (CLDEQ-8)

1. Questions about **EYE DISCOMFORT**:

a. During a typical day in the past 2 weeks, **how often** did your eyes feel discomfort while wearing your contact lenses?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt discomfort with your contact lenses, **how intense was this feeling of discomfort…**

b. At the end of your wearing time?

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

2. Questions about **EYE DRYNESS**:

a. During a typical day in the past 2 weeks, **how often** did your eyes feel dry?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your eyes felt dry, **how intense was this feeling of dryness**…

b. At the end of your wearing time?

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

3. Questions about **CHANGEABLE, BLURRY VISION:**

a. During a typical day in the past 2 weeks, **how often** did your vision change between clear and blurry or foggy while wearing your contact lenses?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

When your vision was blurry, **how noticeable was the changeable, blurry, or foggy vision** …

b. At the end of your wearing time?

Never have it	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

4. Question about **CLOSING YOUR EYES:** During a typical day in the past 2 weeks, **how often** did your **eyes bother you so much that you wanted to close them**?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

5. Question about **REMOVING YOUR LENSES:** How often during the past 2 weeks, did your eyes *bother you so much* while wearing your contact lenses that you felt as if you needed to stop whatever you were doing and **take out your contact lenses**?

1 Never
2 Less than once a week
3 Weekly
4 Several times a week
5 Daily
6 Several times a day