EORTC QLQ – OPT30

Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems during the past week. Please answer by circling the number that best applies to you.

During the past week:	**Not at all**	**A little**	**Quite a bit**	**Very much**
31. Did you have the sensation of grittiness or the feeling of a foreign body in the treated eye?	1	2	3	4
32. Did you feel any pain, soreness or discomfort in or around the treated eye?	1	2	3	4
33. Did you have any itching in your treated eye?	1	2	3	4
34. Did watering in the treated eye trouble you?	1	2	3	4
35. Were you troubled by any discharge from your treated eye?	1	2	3	4
36. Did you suffer from dryness in your treated eye?	1	2	3	4
37. Were you troubled by any defects in your side vision?	1	2	3	4
38. Were you troubled by double vision when looking straight-ahead?	1	2	3	4
39. Were you troubled by double vision when looking side-ways?	1	2	3	4
40. Did the vision of the treated eye interfere with the other eye?	1	2	3	4
41. Did you have headaches?	1	2	3	4
42. Were you worried about your health in the future?	1	2	3	4
43. Were you worried about the tumour recurring in the treated eye?	1	2	3	4
44. Were you worried about a tumour recurring in other areas of the body?	1	2	3	4
45. Were you worried about losing the eye?	1	2	3	4
46. Did you have difficulty driving in daylight because of your vision?	1	2	3	4
47. Did you have difficulty driving in the dark because of your vision?	1	2	3	4
48. Has your appearance bothered you?	1	2	3	4

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During the past week:	**Not at all**	**A little**	**Quite a bit**	**Very much**
49. Were you dissatisfied with the cosmetic result of the surgery?	1	2	3	4
50. Did you have difficulty pouring (e.g., tea or coffee)?	1	2	3	4
51. Did you have difficulty seeing to walk in crowded areas?	1	2	3	4
52. Did you have any difficulty with steps or pavements?	1	2	3	4
53. Did you have any difficulty walking downstairs or on uneven ground?	1	2	3	4
54. Did you have difficulty judging distances?	1	2	3	4
55. Were your activities limited in any way because of your vision?	1	2	3	4
56. Did you have difficulty reading because of your vision?	1	2	3	4

Answer the following questions if applicable:

57. Did things appear distorted out of your treated eye?	1	2	3	4
58. Did you see flashes or balls of light with your treated eye?	1	2	3	4
59. Did you see floaters with your treated eye?	1	2	3	4
60. Did your eye feel uncomfortable in bright light?	1	2	3	4