CVSS17

Name, Surname:____________________________________________________________

Age:___  Date:________

Please reply to the following questions by circling the number corresponding to your response. Note that the questions refer to your use of a computer at work during the past 4 weeks using, if needed, your regular glasses or contact lenses.

A2. Do the letters on the screen become blurred when working on the computer?

1. No, not at all  2. Yes, but only a little  3. Yes, a little blurred
4. Yes, moderately blurred  5. Yes, quite blurred  6. Yes, very blurred

A4. Do your eyes feel tired during or after working on the computer?

5. Frequently  6. Almost always  7. Always

A9. Do your eyes hurt when working on the computer?


A17. Do your eyes feel heavy after working on the computer for some time?


A20. Do you need to blink a lot while working on the computer?

A21. Do you ever get a burning sensation in your eyes?

4. Always  
3. Frequently  
2. Rarely  
1. Never

A22. Do you need to strain your eyes to see well after spending time on the computer?

6. Yes, very much  
5. Yes, a lot  
4. Yes, moderately  
3. Yes, a little  
2. Yes, but not much  
1. Not at all

A28. Do you feel your eyes cross when reading from or writing on the computer?

4. Always  
3. Frequently  
2. Rarely  
1. Never

A30. Do you see double after spending several hours on the computer?

6. Yes, very much  
5. Yes, a lot  
4. Yes, a moderate amount  
3. Yes, a little  
2. Yes, but not much  
1. No

A32. Do your eyes ever sting?

1. Never  
2. Rarely  
3. Frequently  
4. Always

A33. Have you noticed that light bothers you after spending time on the computer?

1. Never  
2. Almost never  
3. Sometimes  
4. Several times  
5. Often  
6. Very often
Indicate the extent to which you have suffered the following signs during the past four working weeks:

<table>
<thead>
<tr>
<th></th>
<th>None (1)</th>
<th>Very little (2)</th>
<th>A little (3)</th>
<th>A moderate amount (4)</th>
<th>A lot (5)</th>
<th>Very much (6)</th>
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</thead>
<tbody>
<tr>
<td>B7. Watery eyes</td>
<td></td>
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<td>B8. Eye redness</td>
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To finish, please indicate to what extent you consider true or false each of the following statements.

C16. At the end of the working day, my eyes feel heavy.
1. Quite false                  2. Completely false
3. Quite true                   4. Completely true

C21. After spending time at the computer, I have to strain to see well.
4. Completely true              3. Quite true
1. Quite false                  2. Completely false

C23. While I’m working, I have to blink because my eyes are dry.
4. Completely true              3. Quite true
1. Quite false                  2. Completely false

C24. After spending time at the computer, lights bother me.
1. Quite false                  2. Completely false
3. Quite true                   4. Completely true