

## APPENDIX 1

**During the task that you just completed, did you experience any of the following symptoms either during or immediately after the task?**

If no, please circle zero for each question. If yes, please rate the intensity of the symptom on a scale from 1 (very mild) to 10 (very severe), with 5 being a moderate response.

Blurred vision while viewing the text	0	1	2	3	4	5	6	7	8	9	10
Blurred vision when looking into the distance at the end of the near task	0	1	2	3	4	5	6	7	8	9	10
Difficulty or slowness in refocusing my eyes from one distance to another	0	1	2	3	4	5	6	7	8	9	10
Irritated or burning eyes	0	1	2	3	4	5	6	7	8	9	10
Dry eyes	0	1	2	3	4	5	6	7	8	9	10
Eyestrain	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
Tired eyes	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to bright lights	0	1	2	3	4	5	6	7	8	9	10
Discomfort in your Eyes	0	1	2	3	4	5	6	7	8	9	10