Appendix 1

Questionnaire of care of ortho-k lens, lens accessories and solution

To be completed by the ortho-k wearer (or guardian)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Gender: M / F</th>
<th>Record no:</th>
</tr>
</thead>
</table>

1. How long have you been wearing ortho-k lenses? _______ month
2. What is your wearing schedule? _______ nights per week ; _______ hours per night

3. What are the purposes of wearing ortho-k lenses? (you can choose more than one option)
   - [ ] Treatment (e.g.: Myopia control)
   - [ ] Safety (e.g.: sport)
   - [ ] Convenience
   - [ ] Beautiful
   - [ ] Other (please explain)

4. Please complete the following table

<table>
<thead>
<tr>
<th>Person in charge</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Lens insertion</td>
<td>[ ] Self</td>
<td>Normally carried out in the morning / evening ________(time)</td>
</tr>
<tr>
<td></td>
<td>[ ] Parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Domestic Helper</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Lens removal</td>
<td>[ ] Self</td>
<td>Normally carried out in the morning / evening ________(time)</td>
</tr>
<tr>
<td></td>
<td>[ ] Parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Domestic Helper</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Lens cleaning</td>
<td>[ ] Self</td>
<td>Normally carried out in the morning / evening ________(time)</td>
</tr>
<tr>
<td></td>
<td>[ ] Parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Domestic Helper</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Accessories cleaning</td>
<td>[ ] Self</td>
<td>Normally carried out in the morning / evening ________(time)</td>
</tr>
<tr>
<td></td>
<td>[ ] Parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Domestic Helper</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A: Lens care procedures

5. How often do you clean the lenses? ___ ___ times per day

6. How do you clean the ortho-k lenses? (Please put a ✔ in the [ ])
   a. Before handling the lenses, did you wash your hands?
      [ ] No (Go to Q6b)
      [ ] Yes
      Did you use the soap or liquid soap?
      [ ] No
      [ ] Yes
      Did you dry up your hands?
      [ ] No
      [ ] Yes, I used the following way
      [ ] Paper towel
      [ ] Facial tissue
      [ ] Toilet paper
      [ ] Bath towel
      [ ] Others

   b. Did you rub the lenses?
      [ ] No (Go to Q6c)
      [ ] Yes, I used the following items
      [ ] Cleaner
      [ ] Multi-purpose solution
      [ ] Others

   c. Did you rinse the lenses?
      [ ] No (Go to Q6d)
      [ ] Yes, I used the following items
      [ ] Multi-purpose solution
      [ ] Distilled water
      [ ] Tap-water
      [ ] Saline
      [ ] Others

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d. What kind of solution did you use for lens storage?
   - Multi-purpose solution
   - Distilled water
   - Tap-water
   - Saline
   - Others__________________________

   Others__________________________

e. How long did you soak the lenses? ____________________ hours

B: Lens accessories care procedures

7. Lens accessories storage and the frequency of cleaning

<table>
<thead>
<tr>
<th>Storage location</th>
<th>How often did you clean the following accessories?</th>
<th>How often did you disinfect the following accessories?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Lens case</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>Kitchen</td>
<td>Once a day</td>
<td>Every_________days</td>
</tr>
<tr>
<td>Living room</td>
<td>After use</td>
<td>Others</td>
</tr>
<tr>
<td>Bedroom</td>
<td>Every_________days</td>
<td>How did you disinfect?</td>
</tr>
<tr>
<td>Others</td>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>b) Suction holder (If not, please go to Q8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td>Never</td>
<td>Every_________days</td>
</tr>
<tr>
<td>Kitchen</td>
<td>Once a day</td>
<td>Others</td>
</tr>
<tr>
<td>Living room</td>
<td>After use</td>
<td></td>
</tr>
<tr>
<td>Bedroom</td>
<td>Every_________days</td>
<td>How did you disinfect?</td>
</tr>
<tr>
<td>Others</td>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

8. How did you clean the lens case?

a. Did you use cleaner?
   - No (Please go to Q8b)
   - Yes, I used the following items
     - Soap
     - Lens cleaner
     - Multi-purpose solution
     - Others__________________________

b. Did you rub the lens case?
   - No
   - Yes

c. Did you rinse the lens case after cleaning?
   - No (Please go to Q8d)
   - Yes, I used the following items
     - Multi-purpose solution
     - Distilled water
     - Tap-water
     - Saline
     - Others__________________________

d. Did you dry the lens case after cleaning?
   - No (Please go to Q9)
   - Yes, I used the following items
     - Air-dry
     - Paper towel
     - Facial tissue
     - Toilet paper
     - Bath towel
     - Others__________________________

9. Did your optometrist provide any instruction on cleaning/disinfecting the suction holder?
   * Yes / No (If no, please go to Q11)

10. If yes, what kind of instruction did s/he provide? (you can choose more than one option)
    - Written
    - Oral
    - Demonstration
    - Others________________________________________

   Please list the instruction on cleaning and disinfecting lens case which your optometrist provided.

11. After air-drying, did you cover up the lens case? * Yes / No

12. After wearing lenses, did you discard the lens solution? * Yes / No
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C: Usage of contact lens solution

13. Did you use artificial tears? * Yes / No (If yes, please state the brand ______________; If not, please go to Q15)

14. How often did you use the artificial tears/eye drops? every __ __ day __ __ times

15. Did you perform enzymatic cleaning on your lenses? * Yes / No (If yes, please state the brand __________; If not, please go to Q17)

16. How often did you perform enzymatic cleaning on your lenses? Once every __________ week

17. Where did you store your lens solution?
   - Bathroom
   - Kitchen
   - Living room
   - Bedroom
   - Others __________

18. Did you cap the solution bottle immediately after use? * Yes / No

19. Did your optometrist provide any instruction on storage and replacement of lens solution? * Yes / No

20. What sort of instruction did your optometrist provide to you? (you can choose more than one option)
   - Written
   - Oral
   - Demonstration
   - Others ________________

~End~