**Ocular Health with Digital Device Usage**

This survey aims to investigate the pattern and responsiveness to ocular complaints among students learning remotely during COVID 19 through a quantitative study.

Please note your name will not be used for analysis of results.

1. How old are you? \*
* 12-13
* 14-15
* 16-17
* 18-19
1. What is your gender? \* Female / Male / Prefer not to say
2. Are you a citizen of Trinidad? \* Yes / No
3. What is your ethnicity? \*
	* Afro-Trinidadian
	* Indo-Trinidad
	* Chinese
	* Syrian/Lebanese
	* Mixed
	* Other
4. What is the nature of community in which you live? \*
	* Rural area
	* Urban area
5. How long have you been living in Trinidad? \*
	* Less than 1 year 1-2 years
	* 3-4 years
	* 5 years & above
6. What form are you in? \*
	* Form 1
	* Form 2
	* Form 3
	* Form 4
	* Form 5
	* Form 6
7. Did you use a digital device for schooling during COVID 19 Pandemic? \* Yes/ No
8. If yes, what Digital Device was used? \*
	* Phone
	* Tablet/iPad
	* Laptop/MacBook
	* Desktop
	* Television
	* Other................
9. Before the closure of school due to COVID-19, How many hours a day on average, did you spend on your digital device daily? \*
	* Less than an hour 1-2 hours
	* 2-4 hours
	* 4-6 hours
	* More than 6 hours
	* Other: …………………….
10. How many hours a day on average, do you spend on your digital device daily as online teaching is taking place?
	* Less than an hour 1-2 hours
	* 2-4 hours
	* 4-6 hours
	* Other …………………….
11. Do you wear glasses or contact lens?
	* Glasses
	* Contact Lenses
	* Both contact lenses and spectacles
	* Neither glasses nor contact lenses
12. If you do wear glasses or contact lens, do you wear them while using your digital device? \*
	* Yes / No/Not applicable
13. What is your preferred position while using your digital device for schooling during COVID 19? \* Check all that applies
	* Sitting
	* Standing
	* Laying down
	* Other
14. How long do you spend in that preferred position while using your digital device?
	* Less than 1 hour 1 - 2 hours
	* 2 - 4 hours
	* 4 - 6 hours
	* More than 6 hours
15. Do you have any eye turns? (Eyes turned inward or outward and commonly known as a "lazy eye" or "kokey eye")
	* Inward
	* Outward
	* No
16. Did you experience headaches with use of your device before COVID-19? \* Yes / No
17. Did you experience dry/gritty eyes (feeling as though something is in your eyes) with use of your device before COVID-19? \* Yes / No
18. Did you experience itchy eyes with use of your device before COVID-19? \* Yes / No
19. Did you experience blurry vision with use of your device before COVID-19? \* Yes / No
20. Did you experience double vision with use of your device before COVID-19? \* Yes / No
21. Do you currently experience headaches with the use of your digital device? \* Yes / No
22. Do you currently experience dry/gritty eyes (feeling as though something is in your eyes) with use of your digital device? \* Yes / No
23. Do you currently experience itchy with the use of your digital device? \* Yes / No
24. Do you currently experience blurry vision with the use of your digital device? \* Yes / No
25. Do you currently experience double vision with the use of your digital device? \* Yes / No
26. Did you try to resolve any of the symptoms above on your own? \* Yes / No
27. If yes, What did you do to resolve the symptoms experienced?
	* …………………………………………………………..
28. When was your last eye exam? \*
	* Within the last 6 months
	* Within the last year
	* More than a year ago
	* More than 2 years ago
	* Never had an eye exam
	* Other:
29. If you got an eye exam done within the last year, was it because of some of the complaints mentioned above? \* Yes / No / Not applicable
30. What was the nature of the treatment?
	* Glasses
	* Eyedrops
	* Vision Therapy
	* Medication
	* Other: …………………………….

 Thank you for participating in this survey

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