Questionnaire 1

We would be grateful if you could answer these three questions **by circling the number that best describes your position** and then answer the following feedback questions on the next page.

1) How is your eye disease currently interfering with your overall quality of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

2) How is your eye disease currently affecting your ability to carry out daily activities?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3) How is your eye disease currently affecting your satisfaction with your appearance?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Feedback questions for questionnaire 1:

How long did it take you to complete the questionnaire?

Did anyone help you to complete the questionnaire, and if so, what kind of help and how much help was provided?

Were there questions that you found confusing or difficult to answer?

Please use the space below if you have other comments about the questionnaire

Questionnaire 2

The following questions deal specifically with your **thyroid eye disease**
*Please focus on **the past week** while answering these questions*

During the past week, to what extent were you limited in carrying out the following activities, because of your **thyroid eye disease?**
Tick the box that matches your answer. The boxes correspond with the answers above them. Please tick only one box for each question.

	Yes, severely limited	Yes, a little limited	No, not at all limited	
1. Bicycling	☐	☐	☐	Never learned to ride a bike ☐
2. Driving	☐	☐	☐	No driver's licence ☐
3. Moving around the house	☐	☐	☐	
4. Walking outdoors	☐	☐	☐	
5. Reading	☐	☐	☐	
6. Watching TV	☐	☐	☐	
7. Hobby or pastime, i.e..........	☐	☐	☐	

	Yes, severely hindered	Yes, a little hindered	No, not at all hindered
8. **During the past week**, did you feel hindered from doing something that you wanted to do because of your thyroid eye disease?	☐	☐	☐

The following questions deal with your thyroid eye disease in general

	Yes, very much so	Yes, a little	No, not at all
9. Do you feel that your appearance has changed because of your thyroid eye disease?	☐	☐	☐
10. Do you feel that you are stared at in the streets because of your thyroid eye disease?	☐	☐	☐
11. Do you feel that people react unpleasantly because of your thyroid eye disease?	☐	☐	☐
12. Do you feel that your thyroid eye disease has an influence on your self-confidence?	☐	☐	☐
13. Do you feel that your thyroid eye disease has an influence on making friends?	☐	☐	☐
14. Do you feel socially isolated because of your thyroid eye disease?	☐	☐	☐
15. Do you feel that you appear less often on photos than before you had thyroid eye disease?	☐	☐	☐
16. Do you try to mask changes in your appearance caused by thyroid eye disease?	☐	☐	☐

Questionnaire 3

We would be grateful if you could answer these nine questions **by circling the letter that best describes your position** and then answer the following feedback questions.

1. Have eye symptoms interfered with your well-being?

   A. Never

   B. Infrequently

   C. Frequently

   D. Most of the time

   E. Always

2. Please rate the current appearance of your eyes.

   A. Excellent

   B. Good

   C. Fair

   D. Poor

   E. Very poor

Please rate how much difficulty you have with the following tasks using the following scale:

A. No difficulty at all

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Stopped because of my eyesight

F. Don't do for reasons other than eyesight

3. Finding something on a crowded shelf

A B C D E F

4. Noticing objects or activities off to the side while you are walking along

A B C D E F

5. Figuring out whether bills you receive are accurate

A B C D E F

6. Recognizing people you know from across the room

A B C D E F

7. Going out to see movies, the theatre, or sports events

A B C D E F

8. Seeing how people react to things you say

A B C D E F

9. Visiting with people you don't know well in their homes, at parties, or in restaurants

A B C D E F