Welcome to our project entitled: <u>Understanding the use of Head-Mounted Devices: The case of eSight</u>

The purpose of this research project consists in studying how you use your eSight device, and identifying which factors are related to your use.

As one of the 1000+ users of these eSight Eyewear, we would like to collect information about your quality of life, your satisfaction and your experience.

This study is conducted by the University of Montreal and is funded by MITACS, a national, not-for profit research organization that manages and funds research and training programs in partnership with universities, industry and Government in Canada.

This funding partnership involves eSight Corporation, the manufacturer of eSight eyewear.

<u>It takes less than an hour to complete the survey and you will have a month to do so.</u> This is a one-time on-line survey. Indeed, once the survey is completed your participation in this study is ended.

This survey will take less than an hour and will include different parts to complete regarding: I) Quality of life; II) Satisfaction; and III) The usage patterns of your eSight device.

Potential risks of this study

There are no known or anticipated risks associated with this project.

It should be noted that participation in this survey is not intended to affect your use of eSight device.The participants are encouraged to continue their normal usage of their device.

Advantages of this study

This study does not lead to a direct benefit to participants. However, the information obtained from it could be useful for the improvement of portable video devices for

Section A: Demographic condition

A1. Age

A2. Gender

- [ ] Female
- [ ] Male

A3. Are you currently a car driver?

- [ ] Yes
- [ ] No

A4. City

A5. Country

A6. Subject's employment/study situation

- [ ] Employed Outside of Home
- [ ] Employed at Home
- [ ] Unemployed
- [ ] Full Time Student
- [ ] Part Time Student
- [ ] Retired

A7. Subject's accomodations

- [ ] House
- [ ] Apartment
- [ ] Townhouse
- [ ] Living/Retirement Community
- [ ] Nursing Home
- [ ] Mobile home
- [ ] Other

Other

A8. Subjects living arrangement

- [ ] Alone
- [ ] With spouse/companion
- [ ] With young children
- [ ] With adult children
- [ ] With sibling or other relatives
- [ ] With parents
- [ ] With guardian
- [ ] Other

Other

A9. Level of study

- [ ] Elementary School (up to 8th grade)
- [ ] Secondary school (completion of high school)
- [ ] Postsecondary school (university)

Section B: Health condition

B1. Do you have a restriction of your visual field?

- Central field loss (I can not see clearly what is in front of me so I need to enlarge, and I see better using the sides of my vision) ☐
- Peripheral field loss (I do not see clearly on the sides of my vision but I see more clearly what is in front of me) ☐
- Both (I can not see clearly what is in front of me so I need to enlarge, and I do not see clearly on the sides of my vision) ☐
- None ☐

B2. What is your ocular diagnosis?

- Retinal detachment ☐
- Diabetic Retinopathy ☐
- Retinopathy of Prematurity ☐
- Stargardt's Disease ☐
- Age Related Macular Degeneration ☐
- Leber's Disease ☐
- Glaucoma ☐
- Ocular Albinism ☐
- Cone Rod Dystrophy ☐
- Choroideremia ☐
- Other ☐

Other

B3. When did your eye condition develop? (number of months or years that have elapsed since the development of your eye condition)

- Less than 3 months ago ☐
- Less than 6 months ago ☐
- Between 6 months and 1 year ago ☐
- Between 1 and 2 years ago ☐
- Between 2 and 5 years ago ☐
- Between 5 and 10 years ago ☐
- More than 10 years ago ☐
- At birth ☐

B4. Do you have another sensory impairment (example : deafness or other)?

- Yes ☐
- No ☐

B5. If yes at the previous question, please indicate : (you need to write in the boxes)

which other sensory impairment ? | | | | | | | | | | |

when did it occur ? | | | | | | | | | | |

B6. Do you have any memory or cognitive impairment?

- Yes ☐
- No ☐

B7. If yes at the previous question, please indicate : (you need to write in the boxes)

which memory or other cognitive impairment ? | | | | | | | | | | |

when did it occur ? | | | | | | | | | | |

B8. Do you have physical (motor) impairment?

- Yes ☐
- No ☐

B9. If yes at the previous question, please indicate : (you need to write in the boxes)

which physical (motor) impairment ? | | | | | | | | | | |

when did it occur ? | | | | | | | | | | |

B10. In general, would you say that your overall health is :

- Excellent ☐
- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐

B11. Compared to 3 months ago, would you say that your overall health is :

- Much better now than three months ago ☐
- Somewhat better now than three months ago ☐
- About the same ☐
- Somewhat worse now than three months ago ☐
- Much worse now than three months ago ☐

B12. During the 3 past months, have you had any of the following problems with your work or other regular daily activities as a result of your <u>physical health</u> (unrelated to your vision loss)?

	Yes	Uncertain	No
Cut down the amount of time you spent on work or other activities	☐	☐	☐
Accomplished less than you would like	☐	☐	☐
Were limited in the kind of work or other activities	☐	☐	☐
Had difficulty performing the work or other activities (for example, it took extra effort)	☐	☐	☐

B13. During the 3 past months, have you had any of the following problems with your work or other regular daily activities as a result of any <u>emotional problems</u> (such as feeling depressed or anxious)?

	Yes	Uncertain	No
Cut down the amount of time you spent on work or other activities	☐	☐	☐
Accomplished less than you would like	☐	☐	☐
Did not do work or other activities as carefully as usual	☐	☐	☐

B14. During the 3 past weeks,

	All of the time	Most of the time	A good bit of the time	Some of the time	None of the time
Did you have a lot of energy?	☐	☐	☐	☐	☐
Have you been a very nervous person?	☐	☐	☐	☐	☐

	All of the time	Most of the time	A good bit of the time	Some of the time	None of the time
Have you felt calm and peaceful?	☐	☐	☐	☐	☐
Have you felt downhearted and blue?	☐	☐	☐	☐	☐
Did you feel worn out?	☐	☐	☐	☐	☐
Did you feel tired?	☐	☐	☐	☐	☐

Section C: PART I : Quality of Life

The purpose of this part is to evaluate how satisfied you are with your eSight Eyewear and the related services you received. The questionnaire consists of 12 satisfaction items.

For each of the 12 items, rate your satisfaction with your esight Eyewear and the related services you received by using the following scale graduated from "not satisfied at all" to "very satisfied".

Please select the field that best describes your degree of satisfaction with each of the 12 items.

D**o not** leave any question unanswered.

C1. Regarding your eSight Eyewear...

How satisfied are you with,

	Not satisfied at all	Not very satisfied	More or less satisfied	Quite satisfied	Very satisfied
the dimensions (size, height, length, width) of your eSight?	☐	☐	☐	☐	☐
the weight of your eSight?	☐	☐	☐	☐	☐
the ease in adjusting (fixing, fastening) the parts of your esight?	☐	☐	☐	☐	☐
how safe and secure your eSight is?	☐	☐	☐	☐	☐
the durability (endurance, resistance to wear) of your eSight?	☐	☐	☐	☐	☐
how easy it is to use your eSight?	☐	☐	☐	☐	☐
how comfortable your eSight is?	☐	☐	☐	☐	☐
how effective your eSight is (the degree to which your device meets your needs)?	☐	☐	☐	☐	☐

C2. Regarding services...

How satisfied are you with,

	Not satisfied at all	Not very satisfied	More or less satisfied	Quite satisfied	Very satisfied
the service delivery program (procedures, length of time) in which you obtained your eSight?	☐	☐	☐	☐	☐

	Not satisfied at all	Not very satisfied	More or less satisfied	Quite satisfied	Very satisfied
the repairs and servicing (maintenance) provided for your eSight?	☐	☐	☐	☐	☐
the quality of the professional services (information, attention) you received for using your eSight?	☐	☐	☐	☐	☐
the follow-up services (continuing support services) received for your eSight?	☐	☐	☐	☐	☐

C3. **Below is t**
he list of the same 1
2 satisfaction items. PLEASE
SELECT THE THREE ITEMS
that you consider to be
the most important to you. Please select the 3 boxes of your choice.

- ☐ Dimensions
- ☐ Weight
- ☐ Adjustments
- ☐ Safety
- ☐ Durability
- ☐ Easy to use
- ☐ Comfort
- ☐ Effectiveness
- ☐ Service delivery
- ☐ Repairs/servicing
- ☐ Professional service
- ☐ Follow-up services

Section D: PART II : Satisfaction with your eSight Eyewear

D1. **Each word or phrase below describes how using an assistive device may affect you. Some may seem unusual but it is important that you answer every one of the 26 items. So, for each word or phrase please select the appropriate box to show how you are affected by using your eSight Eyewear. The boxes are graduated from "-3" (the level you feel affected decreases) and "+3" (the level you feel affected increases).**

	-3	-2	-1	0	+1	+2	+3
1. Competence	☐	☐	☐	☐	☐	☐	☐

	-3	-2	-1	0	+1	+2	+3
2. Happiness	☐	☐	☐	☐	☐	☐	☐
3. Independence	☐	☐	☐	☐	☐	☐	☐
4. Adequacy	☐	☐	☐	☐	☐	☐	☐
5. Confusion	☐	☐	☐	☐	☐	☐	☐
6. Efficiency	☐	☐	☐	☐	☐	☐	☐
7. Self-esteem	☐	☐	☐	☐	☐	☐	☐
8. Productivity	☐	☐	☐	☐	☐	☐	☐
9. Security	☐	☐	☐	☐	☐	☐	☐
10. Frustration	☐	☐	☐	☐	☐	☐	☐
11. Usefulness	☐	☐	☐	☐	☐	☐	☐
12. Self-confidence	☐	☐	☐	☐	☐	☐	☐
13. Expertise	☐	☐	☐	☐	☐	☐	☐
14. Skillfulness	☐	☐	☐	☐	☐	☐	☐
15. Well-being	☐	☐	☐	☐	☐	☐	☐
16. Capability	☐	☐	☐	☐	☐	☐	☐
17. Quality of life	☐	☐	☐	☐	☐	☐	☐
18. Performance	☐	☐	☐	☐	☐	☐	☐
19. Sense of power	☐	☐	☐	☐	☐	☐	☐
20. Sense of control	☐	☐	☐	☐	☐	☐	☐
21. Embarrassment	☐	☐	☐	☐	☐	☐	☐
22. Willingness to take chances	☐	☐	☐	☐	☐	☐	☐
23. Ability to participate	☐	☐	☐	☐	☐	☐	☐
24. Eagerness to try new things	☐	☐	☐	☐	☐	☐	☐
25. Ability to adapt to the activities of daily living	☐	☐	☐	☐	☐	☐	☐

	-3	-2	-1	0	+1	+2	+3
26. Ability to take advantage of opportunities	☐	☐	☐	☐	☐	☐	☐

Section E: PART III : How you currently use your eSight Eyewear

E1. Step 1: You and your eSight device

Which eSight device version do you own?

- ☐ eSight 2 (bought before April 2017)
- ☐ eSight 3 (bought after April 2017)

E2. When did you buy the eSight device?

- ☐ Less than 3 months ago
- ☐ Between 3 and 6 months ago
- ☐ Between 6 and 12 months ago
- ☐ Between 12 and 18 months ago
- ☐ Between 18- and 24 months ago
- ☐ More than 24 months ago

E3. When did you start using your eSight device?

- ☐ Less than 3 months ago
- ☐ Between 3 and 6 months ago
- ☐ Between 6 and 12 months ago
- ☐ Between 12 and 18 months ago
- ☐ Between 18 and 24 months ago
- ☐ More than 24 months ago

E4. If you started to use it more than 1 month after the purchase, please explain why in the box below?

E5. What is your frequency of utilization?

- Everyday ☐
- Between 2 and 3 a week ☐
- Between 4 and 5 a week ☐
- Once a week ☐
- Between 2 and 3 a month ☐
- Between 4 and 5 a month ☐
- Once a month ☐
- Less than once a month ☐

E6. What is the average consecutive time of your eSight device utilization?

- Less than half an hour ☐
- Between 30 minutes and 1 hour ☐
- Between 1 and 2 hours ☐
- Between 2 and 4 hours ☐
- Between 4 and 8 hours ☐
- More than 8 hours ☐

E7. When did you use your eSight device the last time?

- Today ☐
- Less than a week ago ☐
- During the past 4 weeks ☐
- Between 2 and 3 months ago ☐
- More than 3 months ago ☐

E8. If you did not use it for more than 3 months, please explain why in the box below?

E9. What is the nature of tasks for which the eSight device was <u>purchased</u>? (Check all that apply)

- Watching TV ☐

- [ ] Reading books, Newspaper print, Typed letter…
- [ ] Shopping
- [ ] Getting around
- [ ] Using my computer
- [ ] Watching events (sports, church, theatre, etc...)
- [ ] Cooking
- [ ] Personal care (washing, makeup, etc...)
- [ ] Socializing with others
- [ ] Meetings, classrooms, etc...
- [ ] Other

Other

E10. What is the nature of tasks for which the eSight device is <u>actually used</u>?

- [ ] Watching TV
- [ ] Reading books, Newspaper print, Typed letter…
- [ ] Shopping
- [ ] Getting around
- [ ] Using my computer
- [ ] Watching events (sport, church, theatre, etc…)
- [ ] Cooking
- [ ] Personal care (washing, makeup, etc…)
- [ ] Socializing with others
- [ ] Meetings, classrooms, etc…
- [ ] I do not use my eSight device anymore.

Other

Other

E11. **What are the most effective activities for which you use the eSight device? (you need to write in the box below)**

E12. **For which activities is the eSight device not effective or useful? (you need to write in the box below)**

E13. **What activities are you disappointed the eSight device does not help you accomplish? (you need to write in the box below)**

E14. **How much is each of the following symptoms affecting you while or just after using the eSight?**

	None	Slight	Moderate	Severe
General discomfort	☐	☐	☐	☐
Headache	☐	☐	☐	☐
Eyestrain	☐	☐	☐	☐
Nausea	☐	☐	☐	☐

	None	Slight	Moderate	Severe
Vertigo	☐	☐	☐	☐
Dizziness eyes open	☐	☐	☐	☐
Dizziness eyes closed	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐

E15. STEP 2: eSight user's characteristics

Have you ever used an electronic video magnifier other than electronic eyewear (head-mounted display)?

Yes ☐

No ☐

E16. Have you ever used another type of electronic eyewear (head-mounted display) other than the eSight device?

Yes ☐

No ☐

E17. If you have used another type of electronic eyewear (head-mounted display) other than the eSight device, please indicate (you need to write in the box following each question) :

Which one(s)? ☐

How often? ☐

Why did you stop to use it? ☐

E18. Do you currently use several low vision aids?

Yes ☐

No ☐

E19. If your are using several low vision aids, please indicate which :

Table-top video magnifier ☐

Hand-held video magnifier ☐

Magnifier software ☐

Special glasses ☐

Hand-held telescope for distance ☐

Hand-held optical magnifier for reading ☐

Smartphone or tablet computer as low vision aid ☐

Cane ☐

Other ☐

Other

E20. To what extent have you adapted to your visual handicap?

Not at all ☐

Slightly ☐

Moderately ☐

Quit a bit ☐

Extremely ☐

E21. During the 3 past months, to what extent has your visual condition worsened?

Not at all ☐

Slightly ☐

Moderately ☐

Quit a bit ☐

Extremely ☐

Other ☐

Other

E22. Do you enjoy using the eSight device?

Not at all ☐

Slightly ☐

Moderately ☐

Quite a bit ☐

Extremely ☐

E23. Regarding the previous question, explain why? (you need to write in the box below) (Optional)

E24. To what extent have you been disappointed using the eSight device?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quit a bit
- ☐ Extremely

E25. Regarding the previous question, please explain why? (you need to write in the box below) (Optional)

E26. In general, to what extent do you think the eSight is right for you?

- ☐ 0: Not at all
- ☐ 1: Slightly
- ☐ 2: Moderately
- ☐ 3: Quit a bit
- ☐ 4: Extremely

E27. To what extent do you think you have the ability to control your usage of the eSight?

- ☐ 0: Not at all
- ☐ 1: Slightly
- ☐ 2: Moderately
- ☐ 3: Quit a bit
- ☐ 4: Extremely

E28. How did you finance the eSight device?

- [ ] Self pay
- [ ] Family
- [ ] Donation
- [ ] Public government
- [ ] Agency
- [ ] Borrowed
- [ ] Rented
- [ ] Other, please indicate :
- [ ] Other

Other

E29. STEP 3: eSight use changes

To what extent do you consider you have integrated the eSight device into your life?

- [ ] Not at all
- [ ] Slightly
- [ ] Moderately
- [ ] Quit a bit
- [ ] Extremely

E30. Regarding the previous question, what are the reasons? (you need to write in the box below) (Optional)

E31. Have you have completely stopped using the eSight device?

- [ ] Yes
- [ ] No

E32. **If you have completely stopped using the eSight device, please write in the box following each question :**

Since when? ☐

What are the reasons? (optional) ☐

E33. **Overall, do you now use the eSight device more or less than at the beginning?**

More ☐

Less ☐

Same ☐

E34. **If you now use the eSight device less than at the beginning, please write in the box following each question :**

Since when? ☐

What are the reasons? (optional) ☐

E35. **Have you reduced using the eSight device for certain tasks?**

Yes ☐

No ☐

E36. **If you have reduced using the eSight device for certain tasks, please write in the box following each question :**

Since when? ☐

What are the reasons? (optional) ☐

E37. **Have you stopped using the eSight device for certain tasks?**

Yes ☐

No ☐

E38. **If you have stopped using the eSight device for certain tasks, please write in the box following each question :**

For which one? ☐

Since when? ☐

What are the reasons? (optional) ☐

E39. **Do you use the eSight device for new tasks that you did not expect before buying?**

Yes ☐

No ☐

E40. **If you use the eSight device for new tasks that you did not expect before buying, please write in the box following each question :**

Since when? ☐

What are the reasons if any? ☐

E41. Part 4: Social and physical environment

Who made the choice to buy your eSight device?

Yourself ☐

Family, friends ☐

Clinician (Ophthalmologist, Optometrist, Specialist in low vision…) ☐

Other ☐

Other

E42. Do your family or friends encourage you to wear the eSight device?

All of the time ☐

Most of the time ☐

A good bit of the time ☐

Some of the time ☐

A little of the time ☐

None of the time ☐

E43. Does your family help you to carry out activities of daily living?

All of the time ☐

Most of the time ☐

A good bit of the time ☐

Some of the time ☐

A little of the time ☐

None of the time ☐

E44. To what extent do you think that the majority of people that are close to you think you should use the eSight?

- 0: Not at all ☐
- 1: Slightly ☐
- 2: Moderately ☐
- 3: Quit a bit ☐
- 4: Extremely ☐

E45. Have elements in the physical environment (architecture, infrastructure, public transports,...) ever influenced your use of eSight?

- Yes ☐
- No ☐

E46. If you have elements in the physical environment that have ever influenced your use of eSight, please write which one in the box below :

E47. Have you ever felt a reaction from people around you towards your eSight device?

- Yes ☐
- No ☐

E48. If you have ever felt a reaction from people around you towards your eSight device, please write in the box following each question :

- The type of reaction? ☐
- Has this reaction led to a change in the use of your eSight in a social setting? ☐

E49. Have strangers ever asked you about your eSight device?

- Yes ☐
- No ☐
- No answer ☐

E50. If yes, please write in the box following each question :

- If it was a positive or negative response? ☐
- What were their and your reactions? ☐

E51. STEP 5: Training/Intervention

Have you received vision rehabilitation services?

- [ ] Yes
- [ ] No

E52. Who introduced you to the eSight device?

- [ ] Clinician (Ophthalmologist, Optometrist, Specialist in low vision…)
- [ ] Family or friends
- [ ] Advertising, social media
- [ ] Associations
- [ ] Other

Other

E53. Would you have prefered it to be another person?

- [ ] Yes
- [ ] No

E54. If you would have prefered it to be another person, please indicate who?

- [ ] Clinician (Ophthalmologist, Optometrist, Specialist in low vision…)
- [ ] Family or friends
- [ ] Advertising, social media
- [ ] Associations
- [ ] Other

Other

E55. **If you would you have prefered it to be another person, what are the reasons? (please write in the box below) (optional)**

E56. **Regarding the training program proposed by eSight (eSkills), to what extent would you consider it helpful?**

- ☐ Very useful
- ☐ Moderately useful
- ☐ Slightly useful
- ☐ Not useful

E57. **Can you explain your choice regarding the "helpful" aspect? (Please write in the box below) (Optional)**

E58. **Regarding the training program proposed by eSight (eSkills), are you satisfied with this training program?**

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Moderately satisfied
- ☐ Not satisfied at all
- ☐ No answer

E59. **Can you please explain your choice regarding the satisfaction with this training program? (you need to write in the box below) (Optional)**

E60. **Have you completed the training program (eSkills)?**

- Entirely ☐
- Half ☐
- More than the half ☐
- Not at all ☐

E61. **If you have not entirely completed the training program, please explain why? (you need to write in the box below)**

E62. **Who or what contributed the most to your training, please write the reasons if any in the boxes following the items?**

- Yourself ☐
- Clinicians ☐
- Professional from eSight ☐
- eSkills program from eSight ☐
- Family ☐
- Friends ☐
- Other, please indicate : ☐

E63. **Ideally, who or what should have contributed the most to your training, please write the reasons if any in the boxes following the items?**

- Yourself ☐
- Clinicians ☐
- Professional from eSight ☐

eSkills program from eSight ☐

Family ☐

Friends ☐

Other, please indicate : ☐

No answer ☐

E64. Are you satisfied with the eSight device follow-up service?

All of the time ☐

Most of the time ☐

A good bit of the time ☐

Some of the time ☐

A little of the time ☐

None of the time ☐

E65. Is there anything else we did not ask you that you wish you would have asked you? (Please write in the box follow)

Yes ☐

No ☐

E66. If there is anything else we did not ask you that you wish we would have asked you, please write in the box below :

E67. You have the option of receiving a summary of the survey results once the study is complete, and including your name for a $20 Starbucks gift card for your participation, as well as including your name in a draw for a $100 Amazon gift card. Check all that apply, and enter your name and your e-mail address (if applicable) (This will not be utilized to link you to your individual survey response in any way.)

I would like to receive a summary sheet of the survey results once the study is complete, my name and my e-mail address are (please write in the box) : ☐

I would like to receive a 20$ Starbucks gift card for your participation and to be entered into a draw for a 100 dollars gift card (to Amazon store), my name and my e-mail address are (please write in the box if it has not already done) : ☐

You have now completed all the questions, thank you for your participation.