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Online™

# Study of Osteoporotic Fractures (SOF)

## Study Collection Forms

### **Visit AA**

#### **Vision**

#### Eye Medications

Form Type: Clinic Interview

#### **LEGEND:**

**Raw form variable** names are located next to the question they represent and do not have a border around the variable name.

**Calculated variable** names are derived from other variables and have a border around the variable name. The calculated variables names are located in close proximity to the questions from which they were derived.

Some of the questions and measurements on these forms are not being released, and therefore no variable name is provided for them.

2. Have you ever been hit in the eye with a fist or an object?

<b><u>Right Eye:</u></b>	<b><u>Left Eye:</u></b>
<input type="checkbox"/> Yes →	<input type="checkbox"/> Yes →
<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Don't know	<input type="checkbox"/> Don't know

If yes, date when hit:

\_\_\_\_ / \_\_\_\_

Month    Year

If yes, date when hit:

\_\_\_\_ / \_\_\_\_

Month    Year

3. Are you currently using eye drops in your eye for any reason?

<b><u>Right Eye:</u></b>	<b><u>Left Eye:</u></b>
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Don't know	<input type="checkbox"/> Don't know

**AARDROPS**

**AALDROPS**

If participant answered yes to question 3, then ask questions 4 and 5. Otherwise, proceed to question 6 page 7.

If drops not listed on pages 5 & 6, then record here:

Right eye: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Left eye: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Ocular History Cont.

4. Please mark any of the eye drops below that are used, which eye and the time taken this morning or last night:(Refer to the medications or eye drops ppt brought with her.)

	<u>Right Eye</u>		<u>Left Eye</u>	
	Strength	Last taken	Strength	Last taken
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AAALAGRL</b></div> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AABETBRL</b></div> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AAALPRL</b></div> Alphagan (brimonidine tartrate)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AABETGRL</b></div> Betagan (levobunolol)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AABETORL</b></div> Betoptic (betaxolol)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AAISOPRL</b></div> Isopto-Carbachol (carbochol)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AADIAMRL</b></div> Diamox (acetazolamide tabs)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AAEPIFRL</b></div> Epifrin (epinephrine borate)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AAIOPRL</b></div> Iopidine (apraclonidine)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"><b>AANEPTRL</b></div> Neptazane (methazolamide tabs)		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : : <input type="checkbox"/> am <input type="checkbox"/> pm

Qust. 4 cont.

<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AACARBRL</b></div>	<b>Right Eye</b>		<b>Left Eye</b>	
	Strength	Last taken	Strength	Last taken
<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AAOCUPRL</b></div> Ocupress (carteolol)		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AAOPTIRL</b></div> Optipranolol (metipranolol)		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
Pilopine gel (may be Pilostat, Pilagan, IsoptoCarpine, or Generic) <div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AAPILGRL</b></div>		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
Pilocarpine (may be Pilostat, Pilagan, IsoptoCarpine, or Generic) <div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AAPILCRL</b></div>		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AAPROPRL</b></div> Propine (dipivefrin)		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
Timoptic <div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AATIMORL</b></div> (timolol maleate)		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
Trusopt <div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AATRUSRL</b></div> (dorzolamide)		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm
Xalatan <div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>AAXALARL</b></div> (latanaprost)		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm		M / D / Y : : <input type="checkbox"/> am <input type="checkbox"/> pm

**AATOPMRL**

5. Are any of these eye medications, drops or ointment, used to lower the pressure in your eyes?

	<b><u>Right Eye:</u></b>		<b><u>Left Eye:</u></b>	
<b>AARDRPP</b>	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<b>AALDRPP</b>
	<input type="checkbox"/> No		<input type="checkbox"/> No	
	<input type="checkbox"/> Don't know		<input type="checkbox"/> Don't know	

6. Have you ever used eye medication, drops or ointments, prescribed by a doctor to lower the pressure in your eyes?

	<b><u>Right Eye:</u></b>		<b><u>Left Eye:</u></b>	
<b>AADRPRX</b>	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<b>AADRPLX</b>
	<input type="checkbox"/> No		<input type="checkbox"/> No	
	<input type="checkbox"/> Don't know		<input type="checkbox"/> Don't know	

7. Do you wear contact lenses?

	<b><u>Right Eye:</u></b>		<b><u>Left Eye:</u></b>	
<input type="checkbox"/> Yes →	<p>If yes, when did you receive your latest right contact lens?</p> <p>____ / ____</p> <p>Month Year</p>	<input type="checkbox"/> Yes →	<p>If yes, when did you receive your latest left contact lens?</p> <p>____ / ____</p> <p>Month Year</p>	
<input type="checkbox"/> No		<input type="checkbox"/> No		
<input type="checkbox"/> DK		<input type="checkbox"/> DK		