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Online™

# Study of Osteoporotic Fractures (SOF)

## Study Collection Forms

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### Visit 6

#### Vision

Vision History

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.



Q. 1 cont.

**Right Eye:**

**Left Eye:**

e. Yag capsulotomy or treatment for 2nd cataract:

**V6RYAG**

- Yes → If yes, date of surgery:  
\_\_\_\_\_ / \_\_\_\_\_  
Month Year
- No
- Don't know

**V6LYAG**

- Yes → If yes, date of surgery:  
\_\_\_\_\_ / \_\_\_\_\_  
Month Year
- No
- Don't know

f. Glaucoma:

**V6RGLAU**

- Yes → If yes, date first told:  
\_\_\_\_\_ / \_\_\_\_\_  
Month Year
- No
- Don't know

**V6LGLAU**

- Yes → If yes, date first told:  
\_\_\_\_\_ / \_\_\_\_\_  
Month Year
- No
- Don't know

g. Macular Degeneration:

**V6RMACD**

- Yes → If yes, date first told:  
\_\_\_\_\_ / \_\_\_\_\_  
Month Year
- No
- Don't know

**V6LMACD**

- Yes → If yes, date first told:  
\_\_\_\_\_ / \_\_\_\_\_  
Month Year
- No
- Don't know

### Ocular History Cont.

#### Right Eye:

#### Left Eye:

h. Uveitis (inflammation of the eye):

#### V6RUVEIT

Yes → If yes, date first told:  
\_\_\_\_ / \_\_\_\_  
Month Year

No

Don't know

#### V6LUVEIT

Yes → If yes, date first told:  
\_\_\_\_ / \_\_\_\_  
Month Year

No

Don't know

i. Stroke or hemorrhage of the eyes:

#### V6RSTRK

Yes → If yes, date first told:  
\_\_\_\_ / \_\_\_\_  
Month Year

No

Don't know

#### V6LSTRK

Yes → If yes, date first told:  
\_\_\_\_ / \_\_\_\_  
Month Year

No

Don't know

j. Diabetes in the eyes:

#### V6RDIAB

Yes → If yes, date first told:  
\_\_\_\_ / \_\_\_\_  
Month Year

No

Don't know

#### V6LDIAB

Yes → If yes, date first told:  
\_\_\_\_ / \_\_\_\_  
Month Year

No

Don't know

k. Blind eye:

#### V6RBLIND

Yes → If yes, reason for loss of sight:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No

Don't know

Date: \_\_\_\_ / \_\_\_\_  
Month Year

#### V6LBLIND

Yes → If yes, reason for loss of sight:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No

Don't know

Date: \_\_\_\_ / \_\_\_\_  
Month Year

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

**Right Eye:**

**Left Eye:**

**V6RHIT**

Yes → If yes, date when hit:  
 \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

No

Don't know

Yes → If yes, date when hit:  
 \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

No

Don't know

**V6LHIT**

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

**Right Eye:**

**Left Eye:**

Yes

No

Don't know

Yes

No

Don't know

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Do you wear eyeglasses to drive or watch television?

- Yes     No     Don't know

8a. If yes, how long have you had this pair?  
\_\_\_\_\_ Years    \_\_\_\_\_ Months     Less than one month

9. For near correction, do you USUALLY wear (check one):

- Don't wear glasses for near correction
- ←  Reading glasses only
- ←  Bifocals
- ←  Trifocals
- ←  Progressive or "hidden" bifocal or trifocal glasses

9a. How long have you had these glasses?  
\_\_\_\_\_ Years    \_\_\_\_\_ Months     Less than one month

10. Have you ever had eye surgery or laser treatment other than cataract surgery?

**V6EYESRG**

Yes  
↓

No → Go to question 11 page 10

Was this (ask a-h):

a. Laser surgery for diabetes?

**Right Eye:**

**V6RSGDB**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

**Left Eye:**

**V6LSGDB**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

b. Laser surgery for macular degeneration?

**V6RSGMD**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

**V6LSGMD**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

c. Glaucoma surgery, including laser surgery for glaucoma?

**V6RSGGL**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

**V6LSGGL**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

d. Retina surgery?

**V6RSGRET**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

**V6LSGRET**

Yes →  
 No  
 DK

**IF YES:**  
Number of surgeries: \_\_\_\_\_  
Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

e. Corneal graft or transplant?

**V6RCORN**

**Right Eye:**

- Yes →
- No
- DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

**V6LCORN** **Left Eye:**

- Yes →
- No
- DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

f. Refractive surgery (a procedure that allows you to either not wear glasses, or to wear less powerful ones)?

**V6RREF**

- Yes →
- No
- DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

**V6LREF**

- Yes →
- No
- DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

g. Enucleation (removal of eye)?

- Yes →
- No
- DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

- Yes →
- No
- DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

h. Other eye surgery?

**V6ROTHSG**

- Yes →
- No
- DK

**IF YES:**  
 Type of surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

**V6LOTHSG**

- Yes →
- No
- DK

**IF YES:**  
 Type of surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

11. Examiner rating of ocular history.

- Excellent
- Satisfactory
- Unsatisfactory

12. Do we need the ophthalmology record?

- Yes
- No
- Don't Know

13. Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



e. Corneal graft or transplant?

**Right Eye:**

Yes →

No

DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

**Left Eye:**

Yes →

No

DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

f. Refractive surgery (a procedure that allows you to either not wear glasses, or to wear less powerful ones)?

Yes →

No

DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

Yes →

No

DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

g. Enucleation (removal of eye)?

Yes →

No

DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

Yes →

No

DK

**IF YES:**  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

h. Other eye surgery?

Yes →

No

DK

**IF YES:**  
 Type of surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

Yes →

No

DK

**IF YES:**  
 Type of surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 Number of surgeries: \_\_\_\_\_  
 Date of most recent surgery: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year

11. Examiner rating of ocular history.

V60CHX

- Excellent       Satisfactory       Unsatisfactory

12. Do we need the ophthalmology record?

- Yes       No       Don't Know

13. Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_