

1 At present time, would you say your eyesight (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor, or are you completely blind?

O Excellent O Good O Fair O Poor O Very Poor O Completely blind How much of the time do you worry about your eyesight?
O None of the time
O A little of the time
O Some of the time
O All of the time

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


4
Have you EVER used eye drops prescribed by a doctor to lower the pressure in your eyes?
RIGHT EYE: O Yes O No O Don't Know V8DRPRX

LEFT EYE: O Yes O No O Don't Know V8DRPLX
5 Have you ever been hit in the eye with a fist or an object?

RIGHT EYE:
\(\begin{aligned} \& O Yes \longrightarrow \\
\& O No \\

\& O Don't Know\end{aligned}\)| Month/year hit: |
| :--- | :--- | :--- |

LEFT EYE:


Make sure that the eye drops were recorded on the Medication Inventory Form (Page 5 of the Clinic Interview Forms).

## If completely blind, stop vision interview and proceed to Ocular History.

The next questions are about how much difficulty, if any, you have doing certain activities while wearing your glasses or contact lenses, if you use them for this activity.

6 have:
O No difficulty at all
O Extreme difficulty
O A little difficulty
O Stopped doing this because of your eyesight
O Moderate difficulty
O Stopped doing this for other reasons or not interested in doing this

