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Vision Interview

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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?**

○ Excellent ○ Good ○ Fair ○ Poor ○ Very Poor ○ Completely blind

2 **How much of the time do you worry about your eyesight?**

○ None of the time ○ A little of the time ○ Some of the time ○ All of the time

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

RIGHT EYE: ○ Yes ○ No ○ Don't Know **LEFT EYE:** ○ Yes ○ No ○ Don't Know

Are these eye drops used to lower the pressure in your eye?
RIGHT EYE: ○ Yes ○ No ○ Don't Know

Are these eye drops used to lower the pressure in your eye?
LEFT EYE: ○ Yes ○ No ○ Don't Know

4 **Have you EVER used eye drops prescribed by a doctor to lower the pressure in your eyes?**

RIGHT EYE: ○ Yes ○ No ○ Don't Know **LEFT EYE:** ○ Yes ○ No ○ Don't Know

5 **Have you ever been hit in the eye with a fist or an object?**

RIGHT EYE:
V8RHIT ○ Yes → Month/year hit: ☐☐ ☐☐
○ No
○ Don't Know

LEFT EYE:
V8LHIT ○ Yes → Month/year hit: ☐☐ ☐☐
○ No
○ Don't Know

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 **How much difficulty do you have reading ordinary print in newspapers? Would you say you have:**

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

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Ocular History

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1 Has a doctor ever told you that you had any of the following?

	RIGHT EYE	LEFT EYE
a. Cataracts? V8RCAT	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LCAT ○ No ○ Don't Know
a.1. Cataract extraction (surgery)? V8RCATEX	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LCATEX ○ No ○ Don't Know
a.2. Combined cataract/glaucoma surgery? V8RCATSG	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LCATSG ○ No ○ Don't Know
a.3. **If YES to a.1. or a.2,** during cataract surgery was a new lens placed in your eye? V8RLENS	○ Yes ○ No ○ Don't Know	○ Yes ○ No ○ Don't Know V8LLENS
a.4. Yag capsulotomy or treatment for 2nd cataract in the same eye? V8RYAG	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LYAG ○ No ○ Don't Know
b. Glaucoma? V8RGLAU	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LGLAU ○ No ○ Don't Know
c. Macular degeneration? V8RMACD	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LMACD ○ No ○ Don't Know
d. Uveitis (inflammation of the eye)? V8RUVEIT	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LUVEIT ○ No ○ Don't Know
e. Stroke or hemmorhage of the eyes? V8RSTRK	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LSTRK ○ No ○ Don't Know
f. Diabetes in the eyes? V8RDIAB	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LDIAB ○ No ○ Don't Know
g. Blind eye?	○ Yes → Month/year first told: ___/___ ○ No ○ Don't Know	○ Yes → Month/year first told: ___/___ V8LBLIND ○ No ○ Don't Know

Reason for loss of sight: _____

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Version 1.0 02.26.02
SOFH1OcularHistory1

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

V8EYESRG ○ Yes ○ No → SKIP TO VISUAL ACUIITY

	RIGHT EYE	LEFT EYE
a. Laser surgery for diabetes?	V8RSGDB ○ Yes ○ No ○ Don't Know	V8LSGDB ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
b. Laser surgery for macular degeneration?	V8RSGMD ○ Yes ○ No ○ Don't Know	V8LSGMD ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
c. Glaucoma surgery, including laser surgery for glaucoma?	V8RSGGL ○ Yes ○ No ○ Don't Know	V8LSGGL ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
d. Retina surgery?	V8RSGRET ○ Yes ○ No ○ Don't Know	V8LSGRET ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
e. Corneal graft or transplant?	V8RCORN ○ Yes ○ No ○ Don't Know	V8LCORN ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
f. Refractive surgery (a procedure that allows you to either not wear glasses, or to wear less powerful ones)?	V8RREF ○ Yes ○ No ○ Don't Know	V8LREF ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
g. Enucleation (removal of eye)?	○ Yes ○ No ○ Don't Know	V8LEYERM ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___
h. Other eye surgery?	V8ROTHSG ○ Yes ○ No ○ Don't Know	V8LOTHSG ○ Yes ○ No ○ Don't Know
	Number of surgeries: ___ Date of most recent ___/___	Number of surgeries: ___ Date of most recent ___/___

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Vision Measures

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1 **Did the participant complete ANY of the vision measurements listed below (besides the Visual Acuity exam)?**

○ Yes ○ No → **STOP. Complete only this page of the Vision Forms Packet and submit to data system. DO NOT SEND REST OF VISION FORMS.**

Vision Checklist

(Complete the vision measures in the following order and indicate which measures were completed by filling in the circle):

○ **Vision Interview**

○ **Ocular History** →

Examiner rating of ocular history: *V8OCHX*

○ Excellent ○ Satisfactory ○ Unsatisfactory

Comments: _____

_____

_____

_____

Functional Vision

○ **Visual Acuity (Form is in the Clinic Interview Packet)**

○ **Contrast Sensitivity**

○ **Auto Refraction**

○ **Intraocular Pressure**

○ **Dilation**

○ **Eye Photographs**