INSTRUCTIONS:

1. In general, we would like you to complete this questionnaire on your own. If you find that you need assistance, please feel free to ask the clinic coordinator to assist you.

2. Please answer every question (unless you are asked to skip questions because they don't apply to you.)

3. Answer the questions by circling the appropriate number.

4. If you are unsure of how to answer a question, please give the best answer you can.

5. Please complete this questionnaire and give it to the clinic coordinator before leaving the center. Do not take it home.

6. If you have any questions, please feel free to ask the clinic coordinator, who will be glad to help you.

PART 1 – GENERAL HEALTH AND VISION

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

(*Circle one*)

Excellent.....1
Very Good 2
Good 3
Fair 4
Poor 5

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

(Circle one)

Excellent.....1
Good 2
Fair.....3
Poor 4
Very Poor 5
Completely Blind 6

3. How much of the time do you worry about your eyesight?

(*Circle one*)

None of the time 1
A little of the time 2
Some of the time 3
Most of the time.....4
All of the time.....5

4. How much pain or discomfort have you had in and around your eyes, (for example, burning, itching, or aching)? Would you say it is:

(*Circle one*)

None 1
Mild 2
Moderate 3
Severe, or.....4
Very Severe.....5

PART 2 – DIFFICULTY WITH ACTIVITIES

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

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

(*Circle one*)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty.....4
Stopped doing this because of your eyesight.....5
Stopped doing this for other reasons or not interested in doing this 6

6. How much difficulty do you have doing work or hobbies that require you to <u>see well up close</u>, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(*Circle one*)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

7. Because of your eyesight, how much difficulty do you have <u>finding something on a crowded shelf</u>?

(*Circle one*)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

8. How much difficulty do you have <u>reading street signs or the names of stores</u>?

(*Circle one*)

No difficulty 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

9. Because of your eyesight, how much difficulty do you have <u>going down steps, stairs, or curbs in dim light or at night</u>?

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not interested in doing this 6

10. Because of your eyesight, how much difficulty do you have <u>noticing objects off to the side while you are walking along</u>?

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not interested in doing this 6

11. Because of your eyesight, how much difficulty do you have <u>seeing how people react to things</u> you say?

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not interested in doing this 6

12. Because of your eyesight, how much difficulty do you have <u>picking out and matching your own clothes?</u>

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not interested in doing this 6

13. Because of your eyesight, how much difficulty do you have <u>visiting with people in their homes, at parties, or in restaurants</u>?

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not interested in doing this 6

14. Because of your eyesight, how much difficulty do you have <u>going out to see movies, plays or sports events</u>?

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not interested in doing this 6

15. Are you <u>currently driving</u>, at least once in a while?

(*Circle one*)

Yes ..... 1 → **Skip to Question # 15C**

No 2

15a. IF NO: Have you <u>never</u> driven a car or have you <u>given up driving</u>?

(*Circle one*)

Never drove ..... 1 → **Skip to Question # 20**

Gave up driving 2

15b. IF YOU GAVE UP DRIVING: Was that <u>mainly because of your eyesight, mainly for some other reason</u>, or <u>both your eyesight and other reasons</u>?

(*Circle one*)

Mainly eyesight 1

Mainly other reasons ..... 2 → **Skip to Question # 20**

Both eyesight and other reasons 3

15c. IF CURRENTLY DRIVING: How much difficulty do you have <u>driving during the daytime in familiar places</u>? Would you say you have:

(Circle one)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

16. How much difficulty do you have <u>driving at night</u>? Would you say you have:

(*Circle one*)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

17. How difficult is it for you to see moving objects, such as people or other cars when <u>driving at night</u>? Would you say you have:

(*Circle one*)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

18. How difficult do oncoming headlights or streetlights make it for you to <u>drive at night</u>? Would you say you have:

(*Circle one*)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not interested in doing this 6

19. How difficult is it for you to read street signs when <u>driving at night</u>? Would you say you have:

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight.....5

Stopped doing this for other reasons or not interested in doing this 6

20. How <u>difficult is it for you to see street signs when you are a passenger</u> in a car at night? Would you say you have:

(*Circle one*)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

PART 3 – RESPONSES TO VISION PROBLEMS

The next questions are about things you may do because of your vision. For each one, please circle the number to indicate whether the statement is true for you <u>all</u>, <u>most</u>, <u>some</u>, <u>a little</u>, or <u>none</u> of the time.

(*Circle one on each line*)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
21. <u>Do you accomplish less</u> than you would like because of your vision?	**1**	**2**	**3**	**4**	**5**
22. <u>Are you limited</u> in how long you can work or do other activities because of your vision?	**1**	**2**	**3**	**4**	**5**
23. Would you say pain or discomfort <u>in or around your eyes</u> for example, burning, itching, or aching, keep you from doing what you'd like to be doing?	**1**	**2**	**3**	**4**	**5**

For each of the following statements, please circle the number to indicate whether the statement is definitely true, mostly true, mostly false, or definitely false for you or if you are not sure.

		(*Circle one on each line*)				
		Definitely True	**Mostly True**	**Not Sure**	**Mostly False**	**Definitely False**
24.	**I stay home most of the time because of my eyesight**	**1**	**2**	**3**	**4**	**5**
25.	**I feel frustrated a lot of the time because of my eyesight**	**1**	**2**	**3**	**4**	**5**
26.	**I have much less control over what I do, because of my eyesight**	**1**	**2**	**3**	**4**	**5**
27.	**Because of my eyesight I have to rely too much on what other people tell me**	**1**	**2**	**3**	**4**	**5**
28.	**I need a lot of help from others because of my eyesight**	**1**	**2**	**3**	**4**	**5**
29.	**I worry about doing things that will embarrass myself or others because of my eyesight**	**1**	**2**	**3**	**4**	**5**

Following are some additional characteristics of vision. Tell us how bothered you are by these items.

		(*Circle one on each line*)			
		Not at all bothered	**A little bothered**	**Somewhat bothered**	**Very bothered**
30.	**Poor vision at night**	**1**	**2**	**3**	**4**
31.	**Problems reading in dim lighting**	**1**	**2**	**3**	**4**
32.	**A dark spot in the middle of my vision in dim lighting**	**1**	**2**	**3**	**4**
33.	**Poor vision in dim lighting**	**1**	**2**	**3**	**4**
34.	**Problems adjusting to the dark when entering a theater**	**1**	**2**	**3**	**4**
35.	**Trouble seeing the stars in the sky at night**	**1**	**2**	**3**	**4**