PART 3 – RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, please cross the box to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

(please cross **ONE** box only for **EACH** question)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
3.17 Do you accomplish less than you would like because of your vision?	☐	☐	☐	☐	☐
3.18 Are you limited in how long you can work or do other activities because of your vision?	☐	☐	☐	☐	☐
3.19 How much does pain or discomfort in or around your eyes, for example, burning, itching or aching, keep you from doing what you'd like to be doing?	☐	☐	☐	☐	☐

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

(please cross **ONE** box only for **EACH** question)	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
3.20 I stay home most of the time because of my eyesight.	☐	☐	☐	☐	☐
3.21 I feel frustrated a lot of the time because of my eyesight.	☐	☐	☐	☐	☐
3.22 I have much less control over what I do, because of my eyesight.	☐	☐	☐	☐	☐
3.23 Because of my eyesight, I have to rely too much on what other people tell me.	☐	☐	☐	☐	☐
3.24 I need a lot of help from others because of my eyesight.	☐	☐	☐	☐	☐
3.25 I worry about doing things that will embarrass myself or others, because of my eyesight.	☐	☐	☐	☐	☐

4. Personal Details

4.1 Please reconfirm your date of birth: Day __ / Month __ / Year 19__

Thank you for completing the questionnaire.
Please SIGN and DATE the form below using blue or black ink. +

Signature:

& **PRINTED** name:

Today's date: Day __ / Month __ / Year 20__

Please check that you have answered **every** question, and **signed and dated** the form.
Return the completed questionnaire in the **Freepost** envelope provided **(no stamps needed)** to:

Freepost RLUJ-TKES-SURB, ASCEND, Richard Doll Building, University of Oxford, Old Road Campus, Headington, Oxford, OX3 7LF

If you have any questions about the study, please contact the coordinating centre in Oxford on **FREEFONE: 0800 585323** (preferably during office hours 9 am - 5 pm, Monday to Friday)

Thank you for your participation in ASCEND

ASCEND-EYE: Visual Function Questionnaire

INSTRUCTIONS FOR COMPLETION:

Please complete the questionnaire in BLOCK CAPITALS using blue or black ink.
Please place a cross in the appropriate box, e.g. Yes [X] No [ ]
(If you make a mistake, fill the entire box and mark the correct box, e.g. Yes [■] No [X])
OR write clearly in the appropriate boxes, e.g. Day 26 / Month 01 / Year 2017 +

Please complete all the questions **as if you were wearing your glasses or contact lenses** (if any).

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

1. Participant Name and Address

Mr Thomas WHITE
24 Raspberry Road, Gardentown
Gardenshire, GA3 5TR

Form ID: A425-9454
Participant Study Ref: A123-4567

2. Eye Events

2.1 Have you had ANY of the following?
(If **Yes**, please give the date you were first diagnosed and the name and town of the hospital you first attended).

a) **Cataract** Yes [ ] No [ ] Day __ / Month __ / Year ____
Name and town of hospital attended:

b) **Age-related macular degeneration** Yes [ ] No [ ] Day __ / Month __ / Year ____
Name and town of hospital attended:

c) **Glaucoma** Yes [ ] No [ ] Day __ / Month __ / Year ____
Name and town of hospital attended:

d) **Retinal vein thrombosis** Yes [ ] No [ ] Day __ / Month __ / Year ____
Name and town of hospital attended:

e) **Other eye problems**
Name and town of hospital attended:
Date: Day __ / Month __ / Year ____

Need help completing this form? Please call Freefone 0800 585323

3. National Eye-Institute Visual Functioning Questionnaire - 25

PART 1 – GENERAL HEALTH AND VISION (please cross **ONE** box only for **EACH** question)

3.1 In general, would you say your overall health is:

Excellent: ☐ **Very good:** ☐ **Good:** ☐ **Fair:** ☐ **Poor:** ☐

3.2 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, or very poor or are you completely blind?

Excellent: ☐ **Good:** ☐ **Fair:** ☐ **Poor:** ☐ **Very poor:** ☐ **Completely blind:** ☐

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

None of the time: ☐ **A little of the time:** ☐ **Some of the time:** ☐ **Most of the time:** ☐ **All of the time:** ☐

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

None: ☐ **Mild:** ☐ **Moderate:** ☐ **Severe:** ☐ **Very severe:** ☐

PART 2 – DIFFICULTY WITH ACTIVITIES (please cross **ONE** box only for **EACH** question)

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.

3.5 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:** ☐

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

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:** ☐

3.7 Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

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:** ☐

3.8 How much difficulty do you have reading street signs or the names of shops?

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:** ☐

3.9 Because of your eyesight, how much difficulty do you have going down steps, stairs, or kerbs in dim light or at night?

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:** ☐

V-080817

3.10 Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

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:** ☐

3.11 Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

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:** ☐

3.12 Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

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:** ☐

3.13 Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

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:** ☐

3.14 Because of your eyesight, how much difficulty do you have going out to see films, plays, or sports events?

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:** ☐

3.15 Are you currently driving, at least once in a while? Yes ☐ No ☐

3.15a **IF NO**: have you never driven a car or have you given up driving?

Never drove: ☐ **Gave up:** ☐ ➔ Skip to Part 3, Q 3.17 on page 4

3.15b **IF YOU GAVE UP DRIVING**: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

Mainly eyesight: ☐ **Mainly other reason:** ☐ **Both eyesight and other reasons:** ☐ ➔ Skip to Part 3, Q 3.17 on page 4

3.15c **IF CURRENTLY DRIVING**: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

No difficulty at all: ☐ **A little difficulty:** ☐ **Moderate difficulty:** ☐ **Extreme difficulty:** ☐

3.16 How much difficulty do you have driving at night? 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:** ☐

3.16A How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the motorway, or in city traffic? 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:** ☐

0 4 2 5 9 4 5 4