Multi-Ethnic Study of Atherosclerosis

Exam 2

MESA

Eye Vision History

Interviewer Administered

Participant Id#:

Acrostic: _____

Date: ☐☐ / ☐☐ / ☐☐☐☐

Month Day Year

The *Eye Vision History* asks about your present and past history of eye conditions and use of eye medications. The information will help in the assessment and understanding of conditions that might be found on retinal photography which might affect your vision.

1 Have you ever been told by an eye doctor that you have or had a **cataract** in either of your eyes?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes

- O No
- O Don't know
- O Refused

→ *skip to #2*

1a Did you have a cataract operation?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes

- O No
- O Don't know
- O Refused

→ *skip to #2*

1b For each eye, when was your first cataract operation?

Right eye

☐☐☐☐ Year

or

- O No operation
- O Don't know
- O Refused

Left eye

☐☐☐☐ Year

or

- O No operation
- O Don't know
- O Refused

2 For the past 3 months, or longer, have you experienced or been told you have **dry eyes**, where your eyes feel like something is in them, itch, burn, feel gritty, that is not related to allergies?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes

- O No
- O Don't know
- O Refused

→ *skip to #3*

2a Have you been using **artificial tears** for your dry eyes for the past three months or more?

- O Yes
- O No
- O Don't know
- O Refused

3 Has a doctor ever said you had **diabetes**, or high blood sugar or sugar in your urine?

- O Yes -- confirmed diabetes
- O Yes -- suspected diabetes or high blood sugar

- O No
- O Don't know
- O Refused

→ *skip to # 4*

3a Have you ever had **laser** treatment applied to the retina, the back of your eye, because of diabetic retinopathy?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

4 Have you ever been told by an eye doctor that you have **glaucoma**, which is the result of high pressure in your eyes?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes

- O No
- O Don't know
- O Refused

→ *skip to # 5*

4a Do you take medications for your glaucoma?

- O Yes

- O No
- O Don't know
- O Refused

→ *skip to # 4c*

4b Did you use **pilocarpine** eye drops as part of your glaucoma medication?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

4c Did you have **surgery** for your glaucoma?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

5 Have you ever been told by a doctor that one of your eyes had a **retinal detachment**?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

6 Have you ever been told by an eye doctor that you have **age-related macular degeneration**?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

→ *skip to #7*

6a Have you ever had laser **treatment** for macular degeneration?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

7 Has either of your eyes been **injured** and required a doctor's care?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

→ *skip to #8*

7a Was this injury from a blunt object like a fist, ball, car dashboard, etc?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

7b Was this injury from a sharp object like a knife, glass, or other object that cut the eye?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

7c Was this injury due to a chemical burn, from substances like acids or lye?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

7d Did this injury occur at your workplace?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

8 How would you rate your **vision** without correction (without eye glasses or contact lenses)?

- O Excellent
- O Good
- O Fair
- O Poor
- O Can't see at all
- O Don't know
- O Refused

9 Do you drive at night?

- O Yes → *skip to # 9b*
- O No
- O Don't know
- O Refused

→ *skip to # 10*

9a Is this because of your vision?

- O Yes
- O No
- O Don't know
- O Refused

→ *skip to # 10*

9b How much difficulty do you have seeing things (like reading road signs) when you drive at night?

- O None
- O A little
- O A moderate amount
- O A lot
- O Don't know
- O Refused

10 Have you ever been told by a doctor that you had **lazy eye or amblyopia**?

- O Yes -- Right eye only
- O Yes -- Left eye only
- O Yes -- Both eyes
- O No
- O Don't know
- O Refused

11 Do you have an optometrist or ophthalmologist that you go to?

- O Yes
- O No
- O Don't know
- O Refused

→ *Questionnaire Completed*

11a If yes, would you give his/her name and telephone number?

Name

Telephone Number ☐☐☐ - ☐☐☐ - ☐☐☐☐

For MESA Field Center Use Only:

Interviewer ID: ☐☐☐ Reviewer ID: ☐☐☐ Data Entry ID: ☐☐☐