

THE SYDNEY MYOPIA STUDY QUESTIONNAIRE

The purpose of this study

The National Health and Medical Research Council has funded the Sydney Myopia Study to look at the frequency of myopia and factors contributing to its development. We will also look at the frequency of other problems affecting children's eyes such as strabismus (turned eye) and amblyopia (lazy eye or poor vision in one eye). You and your child are invited to participate in this large study that will involve children from all over Sydney.

This questionnaire will give us important information relating to you, your child and your family. Please take as much time as necessary to complete it. All of the answers you provide will be regarded as strictly confidential.

In a few weeks we will provide your child with a complete eye test, and a report will be sent to you. We have now examined 1765 Year-1 children from across Sydney and hope to test a similar number of Year-7 students.

Common questions and answers

What is myopia?

People with myopia, or short-sightedness, are usually not able to see objects in the distance clearly, so that they may find it hard to read signs, play ball games or see the classroom board.

What occurs in the eye?

The eye normally focuses light on the back of the eye (retina) so that you can see objects clearly. However, in a myopic eye, which is too long, the light is focused in front of the retina, so that objects are blurred.

When and why myopia occurs?

Myopia usually develops during a child's school years. The exact cause is unknown. It can occur in some families (genetic) or in association with some diseases. Recent evidence also suggests that some environmental factors may play a part.

Why is myopia a problem?

While vision problems can usually be corrected with glasses, myopia can lead to other eye diseases as a person gets older. In addition, there is evidence that the number of people with myopia is increasing worldwide.

Guidelines

- Where possible we would like one parent or guardian to take responsibility for completing the questionnaire in consultation with other family members/caregivers.
- Please attempt to answer every question. In some circumstances you will be directed to skip questions because they do not apply to you.
- If you have difficulty with a question, please give the best response you can and make a comment in the margin.
- We understand that some children will not be living with both, or even one of their biological parents, and we ask you to please note this in completing the relevant parts of the questionnaire.
- The majority of questions in this questionnaire are standard questions derived from the Australian Bureau of Statistics (ABS) National Census, the NSW Child Health Survey and other international eye studies.
- Please feel free to ask our staff for assistance. They can be contacted on the telephone numbers below.

Please note: While it would greatly assist the examiners if the questionnaire was completed prior to your child's examination, it will be possible to collect it from you later.

Statement of confidentiality

Information that would permit the identification of any person completing this questionnaire will be regarded as strictly confidential. All information provided will be used only for the Sydney Myopia Study and will not be disclosed or released for any other purpose without your consent.

You may correct any personal information provided at any time by contacting:

Administration
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ABOUT YOUR CHILD

Personal Information

1. Your child's name: _____
(First name) *(Family name)*

2. Your child's address: _____

3. Suburb _____ Postcode

4. How long has your child lived in the above suburb? /
(years) *(months)*

5. Since your child was born, where else has he/she lived?

	Location	Length of time at location	From age- to age
1			
2			
3			
4			
5			
6			

6. Gender (please tick): Female Male

7. Date of birth: /
(day) *(month)* *(year)*

8. In which country was your child born: _____

Parent's name: _____

Telephone (day): _____

Telephone (night): _____

Mobile: _____

Email: _____

9. Could you please provide us with the details of three people we could contact to obtain your address if you were to move?

No (**go to question 13**)

Yes (please fill in details below)

10. **Contact 1**

Name _____ Telephone _____

Address _____

Relationship _____

11. **Contact 2**

Name _____ Telephone _____

Address _____

Relationship _____

12. **Contact 3**

Name _____ Telephone _____

Address _____

Relationship _____

General Practitioner (GP)

13. Who is your child's GP? _____

14. What is the address of his/her surgery? _____

15. When did your child last visit his/her GP? _____ weeks/months ago (*please circle*)

16. On average, how many times per year does your child visit the GP? _____ per year

17. Please tick the box if you do not want a report outlining the results of the examination to also be sent to your nominated GP.

I don't want a report to be sent to my child's GP.

Vision and Hearing Questions

The following questions are important because certain hearing and eye conditions can affect your child's schooling.

Hearing Questions

18. Has your child ever had his/her hearing tested?

No (go to question 26)

Unsure (go to question 26)

Yes

19. If yes, what age? _____ Who performed the test? _____

20. Did you receive a written report?

No

Unsure

Yes

21. Were there any abnormalities found with your child's hearing?

No

Unsure

Yes

22. Did your child visit a local doctor or a hearing specialist for further testing?

No

Unsure

Yes

23. Were you told what was wrong with your child's hearing?

No (go to question 26)

Unsure (go to question 26)

Yes

If yes, the problem was? _____

24. How many months/years ago was the problem reported? /
(years) (months)

25. Which ear was involved?

Right ear

Both ears

Left ear

Unsure

Any other comments? _____

Vision Questions

26. Has your child ever had his/her vision tested?

No (go to question 33)

Unsure (go to question 33)

Yes

27. If yes, what age? _____ Who performed the test? _____

28. Did you receive a written report?

No

Unsure

Yes

29. Were there any abnormalities found with your child's eyes?

No (**go to question 33**)

Unsure

Yes

If yes, the problem was: _____

30. Did your child visit a local doctor or eye practitioner for further testing of the problem?

No

Unsure

Yes

31. Were you told what was wrong with your child's eyes?

No (**go to question 33**)

Unsure (**go to question 33**)

Yes

32. How many months ago was the problem reported?

/
(years) (months)

33. Does your child have any of the following sight problems?

Totally blind in both eyes

Partially blind in both eyes

Totally blind in 1 eye only

Partially blind in 1 eye only

Glaucoma

Trachoma

Cataract

Don't know

Other _____

34. Which eye was involved?

Right eye

Both eyes

Left eye

Unsure

35. Is your child colour blind?

No

Unsure

Yes

36. Does your child have any other sight problems?

No

Unsure

Yes

If yes, please describe: _____

The following section asks you about any visits your child may have had to an eye practitioner. An eye practitioner includes:

- ♦ Ophthalmologist (eye specialist)
- ♦ Optometrist
- ♦ Orthoptist (eye therapist)

37. How long ago did your child last see an eye specialist or optometrist?

- | | |
|--|---|
| <input type="checkbox"/> Never (go to question 41) | <input type="checkbox"/> 2 to less than 5 years |
| <input type="checkbox"/> Less than 1 year | <input type="checkbox"/> 5 years or more |
| <input type="checkbox"/> 1 to less than 2 years | <input type="checkbox"/> Don't know (go to question 41) |

38. Does your child attend regular eye examinations?

- | | |
|---|---|
| <input type="checkbox"/> No (go to question 41) | <input type="checkbox"/> Unsure (go to question 41) |
| <input type="checkbox"/> Yes | |

39. Which eye practitioner(s) has your child seen (currently or in the past)?

- | | |
|---|------------------------------|
| <input type="checkbox"/> Ophthalmologist (Eye Specialist) | ___/___/___ (date last seen) |
| Name: _____ | Suburb: _____ |
| <input type="checkbox"/> Optometrist | ___/___/___ (date last seen) |
| Name: _____ | Suburb: _____ |
| <input type="checkbox"/> Orthoptist (Eye Therapist) | ___/___/___ (date last seen) |
| Name: _____ | Suburb: _____ |
| <input type="checkbox"/> Unsure | ___/___/___ (date last seen) |
| Name: _____ | Suburb: _____ |

40. How often is the eye practitioner seen? (refer to the eye practitioner that the child sees most often)

- | | |
|---|--|
| <input type="checkbox"/> More than once in 6 months | <input type="checkbox"/> Once a year |
| <input type="checkbox"/> Every 6 months | <input type="checkbox"/> Less than once a year |

Any other comments? _____

41. Does your child **currently** wear glasses or contact lenses to correct, or partially correct, his/her eyesight?

- | |
|---|
| <input type="checkbox"/> No (go to question 44) |
| <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Contact lenses |

42. How often are the glasses or contact lenses worn?

- All the time
- Most of the time
- Sometimes
- Hardly ever
- Only when eyes feel tired

43. Why were the glasses/contact lenses prescribed? (*You may tick more than one box*)

- Astigmatism
- Short-sightedness / Myopia
- Long-sightedness / Hyperopia
- Don't know
- Other (please describe) _____

44. Has your child worn glasses or contact lenses **in the past**, but no longer needs to wear them?

- No (**go to question 48**)
- Unsure (**go to question 48**)
- Yes

If yes, please state the date and age when first prescribed _____

Date stopped: /
(month) (year)

Reason stopped _____

45. How often did your child wear their glasses / contact lenses?

- All the time
- Most of the time
- Sometimes
- Hardly ever
- Only when eyes feel tired

46. Do you have your child's old glasses?

- No (**go to question 48**)
- Yes (could the child please bring the glasses with them to the examination)

47. Do you have a copy of your child's last prescription?

No

Yes

Please attach a copy of the prescription below.

Please tick if you want the original prescription to be returned to you

(Attach prescription here)

48. Has your child had one or more of the following treatments for myopia (short-sightedness)?
- Bifocals
 - Progressive lenses (multifocal)
 - Atropine eye drops
 - Orthokeratology
 - None of the above
 - Don't know
49. Has an eye practitioner ever noted your child to have a lazy or weak eye (amblyopia)?
- No (**go to question 52**) Unsure (**go to question 52**)
 - Yes
50. How old was your child when he/she was diagnosed with amblyopia?
- years months*
51. Which eye was affected?
- Right eye Both eyes
 - Left eye
52. Has your child ever worn an eye patch?
- No (**go to question 54**)
 - Yes
- If yes, for how long: _____
53. On which eye was the patch worn?
- Right eye
 - Left eye
 - Both eyes, alternately
54. Have you ever been told by an eye practitioner that your child has strabismus (turned eye or squint)?
- No (**go to question 56**) Unsure (**go to question 56**)
 - Yes
55. Has your child received treatment for this condition?
- No Unsure
 - Yes (please describe) _____
56. Has your child ever had eye surgery?
- No (**go to question 58**)
 - Yes (If yes, what was it for?)
 - Strabismus (turned eye or squint)*
 - Other (please describe)* _____

57. When was the eye surgery performed? /
(month) (year)

How old was your child? _____

On which eye was the surgery performed?

- Right eye Both eyes, alternately
 Left eye Unsure

58. Has your child ever sustained any serious injury to the eyes or area around the eyes?

- No (**go to question 60**) Unsure (**go to question 60**)
 Yes

If yes, explain the injury (please describe) _____

59. Was your child's vision affected by the injury?

- No Unsure
 Yes

60. Have you ever been told by an eye practitioner that your child has dry eyes?

- No Unsure
 Yes

61. Is your child **currently** using any eye drops/ointments?

- No Unsure
 Yes

*Please list all eye drops/ointments **currently** used.*

	Name of eye drop/ointment	Times per day	Date started month/year	Reason for using
1.				
2.				
3.				

62. Has your child ever used eye drops/ointment in the **past**?

- No Unsure
 Yes

*Please list all eye drops/ointments **previously** used.*

	Name of eye drop/ointment	Times per day	Duration of usage	Age at time of usage	Reason for using
1.					
2.					
3.					

63. Has your child ever complained of any eye problems in the past?

- No Unsure
 Yes

64. Has anyone, other than a health practitioner ever noted a problem with your child's eyesight?

- No (go to question 66) Unsure (go to question 66)
 Yes

65. What was thought to be wrong with his/her eyes?

- Eyes not looking in same direction (squint or turned eye)
 Colour blind
 Amblyopia (weak or lazy eye)
 Cannot see blackboard
 Something else (please describe) _____
 Don't know

66. Do you think your child might need to wear glasses?

- No Unsure
 Yes (please give the reason) _____

67. Have you noticed your child to have a squint (turned eye)?

- No (go to question 71) Unsure (go to question 71)
 Yes

68. How old was your child when you first noticed this?

years months

69. Which eye was affected?

- Right eye Left eye

70. Has a doctor checked this?

- No
 Yes

If yes, how many year(s)/month(s) were there between the first time you noticed this and the time your child was seen by the doctor?

years months

Questions on General Health

The following questions are relating to your child's past and current health. A chronic illness or disability is a condition that has been detected in the past and is ongoing, requiring treatment.

71. Has your child ever been diagnosed with a chronic illness or disability?

- No (go to question 76) Unsure (go to question 76)
 Yes

72. What was the nature of the illness or disability? _____

73. Does your child still have this condition?

- No Unsure
 Yes

74. Does your child receive treatment for this condition?

- No (go to question 76) Unsure (go to question 76)
 Yes

75. Please tick the treatment(s) given:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medicine prescribed | <input type="checkbox"/> Surgery | <input type="checkbox"/> Given injections |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Dental treatment |
| <input type="checkbox"/> Naturopathy | <input type="checkbox"/> Chiropractic treatment | |
| <input type="checkbox"/> Homeopathic treatment | | |
| <input type="checkbox"/> Counselling / guidance | | |
| <input type="checkbox"/> Other (please describe) _____ | | |

The following questions refer to a condition that has been detected for the 1st time in the last 2 weeks. For example: the flu.

76. Has your child visited a doctor in the last 2 weeks?

- No (go to question 83) Unsure (go to question 83)
 Yes

If yes, please state the reason(s)

77. Was any treatment given?

- No (go to question 83) Unsure (go to question 83)
 Yes

78. What treatment(s) were given:
 Medicine prescribed Surgery performed or recommended
 Referred to another practitioner (specify) _____
 Other (specify) _____

79. Has your child had a second reason to visit a doctor during the last 2 weeks?
 No (**go to question 83**) Unsure (**go to question 83**)
 Yes

80. What was the illness or injury that caused your child's second visit to the doctor?

81. Was any treatment given?
 No (**go to question 83**) Unsure (**go to question 83**)
 Yes

82. Please tick the treatment(s) given:
 Medicine prescribed Surgery performed or recommended
 Referred to another practitioner/ doctor
 Other (please describe) _____

The following questions refer to an illness that was severe enough to require your child's admission into hospital or day surgery. For example: appendicitis.

83. Has your child had any periods of prolonged absence from school due to ill health?
 No Unsure
 Yes
If yes, how many days? _____

84. Has your child had a major illness in the past that has required admission to hospital or day surgery?
 No (**go to question 92**) Unsure (**go to question 92**)
 Yes

85. Please describe the reason for your child's admission? _____

86. At what age did this occur? _____

87. Did your child have surgery?

- No (go to question 92) Unsure (go to question 92)
 Yes

88. Please name or describe the **surgical procedure** _____

89. What was the name of the hospital and in which suburb was it located? _____

90. Has your child had more than one admission to hospital or day surgery?

- No (go to question 92) Unsure (go to question 92)
 Yes

91. Please list the name of the hospital, the suburb in which it was located, the reason for the admission and the date of the admission.

● Hospital: _____

Suburb: _____ Date: ____ / ____ / ____ (day/month/year)

Reason: _____

● Hospital: _____

Suburb: _____ Date: ____ / ____ / ____ (day/month/year)

Reason: _____

***The following questions relate to medications that your child is currently using:
Please note that vitamins, inhaled medicines, skin lotions, eye-drops, laxatives, homeopathic and herbal remedies should also be included.***

92. Has your child taken any medication(s) in the **last 2 weeks**?

- No (go to question 93) Unsure (go to question 93)
 Yes (If yes, please list all the medications in the table below)

	Medication name	Method of intake (ie. oral, injected)	Number of times per day	Date started	Reason for taking
1					
2					
3					
4					

Medications used for a period of at least 3 months

93. In the **past** has there been any *prescribed* or *non-prescribed* medication(s) that your child has taken every day (or nearly every day) for a period of at least 3 months?

- No (go to question 94) Unsure (go to question 94)
 Yes (If yes, please list all the medications in the table below)

Please list all **prescribed** medications taken for a period of at least 3 months.

	Medication name	Method of intake (ie oral, injected)	How many times a day	Duration in weeks	Reason for taking	Age at time
1						
2						
3						
4						
5						

Please list all **over the counter** medications (*medications not requiring a doctors prescription for purchase*), taken for a period of at least 3 months.

	Medication name	Method of intake (ie oral, injected)	How many times a day	Duration in weeks	Reason for taking	Age at time
1						
2						
3						
4						
5						

We would like to ask you about common medical conditions. Certain conditions have been shown to be associated with myopia.

94. Has your child ever been told by a doctor or nurse that he/she has asthma?

- No (go to question 96) Unsure (go to question 96)
 Yes

95. Does your child still have asthma?

No

Unsure

Yes

96. Has your child ever been told by a doctor that he/she has eczema?

No (go to question 98)

Unsure (go to question 98)

Yes

97. Does your child still have eczema?

No

Unsure

Yes

98. Do you (the mother) smoke?

No

Yes

99. Do other people living in your home smoke inside the house?

No

Yes

If you answered *Yes* to questions 98 or 99, please complete the table below.

Cigarettes/day	Mother	Father	Other
1-10/ day			
11-20/ day			
21-40/day			
41+/day			

100. Was there any delay in your child's early development?

No

Unsure

Yes (Please tick below)

Delayed development in:

Sitting

Walking

Talking

Other (please describe) _____

101. Has your child had any learning difficulties at school?

No

Unsure

Yes

If yes, please describe _____

102. Have you ever been told that your child has Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?

No (go to question 105)

Unsure (go to question 105)

Yes

103. What age was your child when you were first told that he/she had Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)

years

months

Don't Know

104. Is your child receiving treatment for this disorder?

No

Unsure

Yes

105. Has your child ever been diagnosed with any of the following?

Epilepsy

Meningitis

Diabetes

Down Syndrome

Stickler Syndrome

Marfan Syndrome

Toxoplasmosis

Congenital heart disease

Other (please describe) _____

*The following questions apply only to **FEMALE STUDENTS**. The start of puberty has been associated with the onset of myopia and can have an effect on eye development. We would like to ask you the following questions so that we can study these effects further. If they do not apply to your child, please skip to question 108.*

106. Has your daughter had a period in the past 12 months?

Yes

Don't know

No

107. How old was she when her periods (or menstrual cycles) started?

Her periods haven't started yet

I'm not sure when her periods started

Her periods started at age /
(years) (months)

Birth History

If you still have your child's health record book (the blue/yellow book) please use it to answer the following questions.

Birth Details:

Please refer to:

NSW	Blue Book	Page 39
WA	Yellow Book	Page 45
SA	Blue Book	Page 38
Tas	Blue Book	Page 57
Qld	Blue Book	Page 20
Vic	Yellow Book	"Birth, Vit K, Hep B, Newborn Examination" section

108. Do you still have your child's State Child Health Record (the blue/yellow book)?

No

Yes

109. Delivery Type

Normal

Breech

Caesarean

Vacuum extraction

Forceps

Other

Don't know

110. What was your child's birth weight? _____ Grams or _____ Pounds _____ Ounces

111. Birth length _____ cms

112. Birth head circumference _____ cms

113. What was your child's gestation period? weeks (go to question 115)

Unsure (go to question 114)

If your child's gestation period is unknown, please try to answer the following question.

114. Was your child born

Late (42 weeks or more)

On time (37-41 weeks gestation)

Early (32-36 weeks gestation)

Very early (31 weeks or less)

115. Was your child admitted to a Neonatal Intensive Care Unit (NICU) after birth?

- No Don't know
 Yes

116. Was your child admitted to a Special Care Nursery (SCN) after birth?

- No (**go to question 118**) Don't know (**go to question 118**)
 Yes

(If your child was admitted to a NICU or SCN please answer the following question)

117. What was the date of discharge? / /
(day) (month) (year)

118. Was this a multiple pregnancy? (eg. twins or triplets)

- No, single birth
 Yes, twins
 Yes, triplets
 Yes, more than triplets

119. Where was your child born:

- In a hospital or birthing centre?

Name of hospital _____

Suburb _____ State _____

- At home
 Other (please describe) _____

120. Did you use your child's health record book to answer the above questions?

- No
 Yes

121. Has your child ever been breastfed?

- No (**go to question 123**) Don't know (**go to question 123**)
 Yes

122. What is the total time your child was breastfed?

- Longer than 3 months
 Longer than 1 week but less than 3 months
 Less than one week
 Unsure

The mother's health during pregnancy can influence her child's development. We would like to know about specific conditions the mother may have experienced during the pregnancy.

123. Were there any problems with the pregnancy?

No Unsure

Yes (If yes, please describe) _____

124. During the pregnancy, did the mother:

	Yes	No	Don't know
Have high blood pressure needing treatment? (admission to hospital or medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes needing insulin injections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes but didn't have insulin injections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a high fever anytime during the pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have Rubella (German measles)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have Mumps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have other health problems? (Please describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

125. During the pregnancy, did the mother ever smoke cigarettes, cigars, pipes or other tobacco products?

No (**go to question 128**) Don't know (**go to question 128**)

Yes

126. How often did the mother smoke cigarettes, cigars, pipes or other tobacco products, while she was pregnant with the child?

Daily Not at all

At least weekly, not daily Don't know

Less often than weekly

127. During the pregnancy, did the mother:

Reduce the amount of tobacco she smoked

Try and give up smoking but were unsuccessful

Successfully give up smoking

None of the above

Don't know

128. During the pregnancy, did the mother share a home with people who smoked indoors?

No

Unsure

Yes

If yes please specify approximately how many cigarettes were smoked indoors a day during the pregnancy: _____

129. During the pregnancy, did the mother take any prescribed medications?

No

Unsure

Yes

Please list all medications which were prescribed by a local doctor

	Medication name	Method of intake (ie oral, injected)	How many times a day	Duration in weeks	Reason for taking
1					
2					
3					
4					
5					

130. During the pregnancy, did the mother take any over-the-counter medications?

No

Unsure

Yes

Please list all over the counter medications (ie a doctors prescription wasn't needed to purchase these medications)

	Medication name	Method of intake (ie oral, injected)	How many times a day	Duration in weeks	Reason for taking
1					
2					
3					
4					
5					
6					

In recent years, researchers have studied the impact a child's environment may have on vision. We are interested in all the activities your child engages in on a regular basis.

131. Please tick the average number of *hours per day* that your child spends doing the following activities.

	<u>ON A SCHOOL WEEKDAY</u>				<u>ON A SCHOOL WEEKEND</u>			
	Not at all	Less than 1 hour	1-2 hours	3 or more hours	Not at all	Less than 1 hour	1-2 hours	3 or more hours
a) Out of doors (<i>in your backyard, walking, riding a bike/scooter</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Outdoor leisure activities (<i>BBQs, picnic, beach, bushwalk</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Watching T.V/ videos /DVDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Playing video games (eg. <i>Playstation</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Drawing, painting and/or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Hobbies and crafts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Cooking, making or constructing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) School homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Reading books for pleasure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Playing musical instruments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Using a computer or playing computer games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Playing <i>hand-held</i> computer games (e.g. <i>Gameboy</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Playing with and caring for pets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Going shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Playing chess, cards or board games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Near/distance work questions

132. Does your child place his/her face unusually close to the book while reading/writing?

- No (**go to question 134**) Unsure (**go to question 134**)
 Yes

133. If your child's reading/writing distance is close, please estimate how close by ticking one box.

- 0 – less than 10 centimetres (0 – less than 4 inches)
 10 – less than 20 centimetres (4 – less than 8 inches)
 20 – less than 30 centimetres (8 – less than 12 inches)
 Unsure

134. When your child is watching TV, how close to the TV does your child sit?

- Less than one metre (less than 3 feet)
 1 – 2 metres (3 – 6 feet)
 2 – 3 metres (6 – 9 feet)
 Greater than 3 metres (greater than 9 feet)

135. When your child plays video games, like Playstation, how close to the screen does he/she sit?

- My child does not play video games
 Less than one metre (less than 3 feet)
 1 – 2 metres (3 – 6 feet)
 2 – 3 metres (6 – 9 feet)
 Greater than 3 metres (greater than 9 feet)

136. Did your child attend preschool?

- No (**go to question 138**) Unsure (**go to question 138**)
 Yes

At what age did your child first attend preschool? /
(years) (months)

137. How many days per week did your child attend preschool? (days)

138. Has your child had any periods of prolonged absence from school due to reason(s) other than ill health (eg. travel, etc)?

- No (**go to question 141**) Unsure (**go to question 141**)
 Yes (please give details below)

139. If yes, how many days or weeks? _____ Reason(s) for absence: _____

140. Please tick when the absence occurred: (You may tick more than one box)

Preschool –Grade 2

Grades 3-6

Grade 7

141. How many days was your child absent from school in the last 12 months?

Up to 5 days

6 – 20 days

More than 20 days

ABOUT YOUR FAMILY

This section will ask about your child's biological (natural) parents and family members to identify genetic associations. People with particular ethnic backgrounds seem to develop myopia more than others. We realise that some parent(s) may not be the biological parent(s) and in some cases not have the knowledge to complete some sections. If this is the case, please tick unsure. Where possible it is preferable that the biological parent completes this section.

Biological Parents

142. Please tick the box that applies to your child:

- Both parents are the biological parents
- Current father is the biological father and current mother is not the biological mother
- Current mother is the biological mother and current father is not the biological father
- Current father is the biological father and no mother present (single father)
- Current mother is the biological mother and no father present (single mother)
- Both parents are **not the** biological parents
- Other (please describe) _____

143. Country of birth of both biological parents?

Mother _____ Tick if unsure

Father _____ Tick if unsure

144. What is the ethnic origin of the child's biological parents? (Provide more than one ethnic group if applicable; e.g. If the father's mother is Caucasian and father's father is East Asian, then you would tick both boxes in the father's column.)

	Mother	Father
Caucasian (European)	<input type="checkbox"/>	<input type="checkbox"/>
East Asian	<input type="checkbox"/>	<input type="checkbox"/>
Indian/ Pakistani/ Sri Lankan	<input type="checkbox"/>	<input type="checkbox"/>
African	<input type="checkbox"/>	<input type="checkbox"/>
Melanesian/ Polynesian	<input type="checkbox"/>	<input type="checkbox"/>
Middle Eastern	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous Australian	<input type="checkbox"/>	<input type="checkbox"/>
South American	<input type="checkbox"/>	<input type="checkbox"/>
Unsure	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe) _____		

145. Which language(s) is most commonly spoken at home? _____

146. Date of Birth of the **biological mother**:

Date of birth: ____ / ____ / ____ (dd/mm/yy) Tick if unsure

147. Current **height** of the **biological mother** ____ cm or ____ feet and ____ inches

Current **weight** of the **biological mother** ____ kg or ____ pounds and ____ ounces

148. Please tick all medical conditions the child's **biological mother** may have had or currently has:

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Unsure | <input type="checkbox"/> Other (please describe)_____ | |

149. Date of birth of the **biological father**:

Date of birth: ____ / ____ / ____ (dd/mm/yy) Tick if unsure

150. Current **height** of the **biological father** ____ cm or ____ feet and ____ inches

Current **weight** of the **biological father** ____ kg or ____ pounds and ____ ounces

151. Please tick all medical conditions the child's **biological father** may have had or currently has:

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Unsure | <input type="checkbox"/> Other (please describe)_____ | |

Biological Family Members

152. Have any of the child's biological family members ever been diagnosed with the following?
(Including mother, father, grandparents or any other family member)

(Please specify which biological family members on the lines below)

- | | |
|--|--|
| <input type="checkbox"/> Marfan's syndrome | <input type="checkbox"/> Stickler syndrome |
| _____ | _____ |
| <input type="checkbox"/> Noonan syndrome | <input type="checkbox"/> Down syndrome |
| _____ | _____ |
| <input type="checkbox"/> Turner's syndrome | <input type="checkbox"/> Unsure |
| _____ | _____ |

153. Has the child's **biological father** ever been diagnosed with amblyopia? (lazy or weak eye/
poor vision in one eye)?

No Unsure

Yes

If yes, which eye(s) was involved?

Right eye Both eyes

Left eye Unsure

At what age was he diagnosed? _____ years

By whom? _____

Did he wear an eye patch for this condition?

Yes Unsure

No

154. Has the child's **biological mother** ever been diagnosed with amblyopia? (lazy or weak eye/
poor vision in one eye)?

No Unsure

Yes

If yes, which eye(s) was involved?

Right eye Both eyes

Left eye Unsure

At what age was she diagnosed? _____ years

By whom? _____

Did she wear an eye patch for this condition?

Yes Unsure

No

155. Has the child's **biological father** ever been diagnosed with strabismus? (squint or turned eye)?

No Unsure

Yes

If yes, which eye(s) was involved?

Right eye Both eyes

Left eye Unsure

At what age was he diagnosed? _____ years

By whom? _____

Did he have surgery to correct the squint?

Yes Unsure

No

156. Has the child's **biological mother** ever been diagnosed with strabismus? (squint or turned eye)?

- No Unsure
 Yes

If yes, which eye(s) was involved?

- Right eye Both eyes
 Left eye Unsure

At what age was she diagnosed? _____ years
 By whom? _____

Did she have surgery to correct the squint?

- Yes Unsure
 No

157. Please state whether anyone in your child's **biological mother's family** has had a cataract operation or any other eye condition?

	Cataract Operation <i>(Age when surgery performed)</i>	Other Eye Condition <i>(Please describe)</i>
<input type="checkbox"/> Mother	_____ years	_____
<input type="checkbox"/> Mother's father	_____ years	_____
<input type="checkbox"/> Mother's mother	_____ years	_____
<input type="checkbox"/> Mother's brothers	_____ years	_____
<input type="checkbox"/> Mother's sisters	_____ years	_____
<input type="checkbox"/> Unsure		

158. Please state whether anyone in your child's **biological father's family** has had a cataract operation or any other eye condition?

	Cataract Operation <i>(Age when surgery performed)</i>	Other Eye Condition <i>(Please describe)</i>
<input type="checkbox"/> Father	_____ years	_____
<input type="checkbox"/> Father's father	_____ years	_____
<input type="checkbox"/> Father's mother	_____ years	_____
<input type="checkbox"/> Father's brothers	_____ years	_____
<input type="checkbox"/> Father's sisters	_____ years	_____
<input type="checkbox"/> Unsure		

159. Please indicate the total number of children in the household

Males Females

160. Please list the full name, sex, year and place of birth for **ALL** brothers and sisters including biological and non-biological.

First name	Family name	Gender	Year of birth	Birthplace Town/country	Same mother	Same father
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

161. Do any of the children living in your household have any known eye problems?

Please list:

Name	Eye Problem

162. This table refers to all children **except** your child involved in the study.

Children	Does the child wear glasses or contact lenses?	At what age did the child start wearing glasses	What does the child wear glasses and/or contact lens primarily for?	Does the child have astigmatism?
1. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. First name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

We would like to know whether other family members, including the parents have eye conditions requiring correction with glasses, contact lenses.

163. Please fill out the tables with reference to your child's *biological* family members.

Family members	Do they wear glasses or contact lenses?	At what age did they start wearing glasses?	What do they wear glasses or contact lens primarily for?	Do they have astigmatism?
1. Father	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. Father's father	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. Father's mother	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. Mother's father	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. Mother's mother	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		<input type="checkbox"/> Seeing clearly in distance (e.g. television, movies) <input type="checkbox"/> Reading, working at a computer, or other close work <input type="checkbox"/> Equally important for distance and close work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Children with parents who are myopic are more likely to develop myopia. We are therefore keen to know the strength of any glasses (or contact lenses) worn by either parent.

164.

Parent 1:

I do not wear glasses/contact lenses

I have enclosed a copy of my glasses/ contact lens prescription.

I give permission for the Sydney Myopia Study to contact my optometrist/ eye specialist to obtain a copy of my glasses/contact lenses prescription.

Eye specialist's/ Optometrist's name:

Address:

Telephone:

PARENT'S NAME: _____

SIGNATURE: _____ DATE: _____

Parent 2:

I do not wear glasses/contact lenses

I have enclosed a copy of my glasses/ contact lens prescription.

I give permission for the Sydney Myopia Study to contact my optometrist/ eye specialist to obtain a copy of my glasses/contact lenses prescription.

Eye specialist's/ Optometrist's name:

Address:

Telephone:

PARENT'S NAME: _____

SIGNATURE: _____ DATE: _____

165. Has anyone in your family had refractive/ laser correction eye surgery?

No (go to question 168)

Yes

166. If yes, what is his or her relation to the child (e.g., father, sister) _____

167. Refractive surgery (laser surgery/ LASIK) was done at the age of _____ years old and for correction of:

Myopia

Presbyopia

Hyperopia

Don't know

Astigmatism

The questions in this section refer to the current parents caring for the child (which in some cases may not be the biological parents).

Current parents

168. Parents' occupation(s):

Mother's Occupation: _____

Current Occupation: _____

Father's Occupation: _____

Current Occupation _____

169. How would you describe the mother's employment status?

Employed full time (includes self employment)

Employed part time (includes self employment)

Unemployed

Home duties

Student and working

Student and not working

Retired

Unable to work due to health problems

Pension

Other _____

170. How would you describe the father's employment status?

- Employed full time (includes self employment)
- Employed part time (includes self employment)
- Unemployed
- Home duties
- Student and working
- Student and not working
- Retired
- Unable to work due to health problems
- Pension
- Other _____

171. What is the highest level of education completed by the mother?

- Never attended school
- Some primary school completed
- Some high school completed
- Completed School Certificate – Intermediate -Year 10 - 4th Form
- Completed HSC - Year 12 – Leaving - 6th Form
- TAFE Certificate or Diploma, including trade certificate
- University, CAE or some other tertiary institute degree
- Higher degree including a Masters or PhD
- Other _____

172. What is the highest level of education completed by the father?

- Never attended school
- Some primary school completed
- Some high school completed
- Completed School Certificate – Intermediate -Year 10 - 4th Form
- Completed HSC - Year 12 – Leaving - 6th Form
- TAFE Certificate or Diploma, including trade certificate
- University, CAE or some other tertiary institute degree
- Higher degree including a Masters or PhD
- Other _____

173. What type of place does the family live in?

- | | |
|--|---|
| <input type="checkbox"/> Own house | <input type="checkbox"/> With relatives |
| <input type="checkbox"/> Own flat/unit | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Rented house | <input type="checkbox"/> Rented flat |
| <input type="checkbox"/> Other (please describe) _____ | |

The date when the questionnaire was completed: / /
(Day) (Month) (Year)

Name of person filling out the questionnaire:

Name _____ Relationship to child _____

Names of other people consulted in filling out this questionnaire:

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Final Comments:

**Thank you for completing this questionnaire.
We look forward to seeing your child at the examination.**