

# THE SYDNEY MYOPIA STUDY QUESTIONNAIRE

## 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 to read off 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 not known. However, 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 myopia is a problem?**

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

## The purpose of this study

The National Health and Medical Research Council has funded the Sydney Myopia Study to look at factors contributing to the development of myopia. 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 recently tested children at a school in Sydney and found they really enjoyed the experience.

## Guidelines

- Where possible we would like one parent or chief child carer to take responsibility for completing the questionnaire in consultation with other family members/caregivers.
- We use the word "parent" or "chief child carer" to cover those the child lives with, who are primarily responsible for the care of the child on a day to day basis. Some children will not be living with both, or even one of their biological parents. In relation to pregnancy and parental health, we require information about the biological parents. We recognise that this will be difficult to provide in some situations, and we ask you to note if this is a problem in completing parts of the questionnaire.
- Please attempt to answer every question. In some circumstances you will be directed to skip questions because they don't apply to you.
- If you have difficulty with a question, please give the best response you can and make a comment in the margin.
- 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

Centre for Vision Research  
Westmead Hospital  
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Fax: 9845 8345

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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	Age of child
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: \_\_\_\_\_

9. Your child's school is: \_\_\_\_\_

10. Your child's grade is: \_\_\_\_\_

Parental contact: \_\_\_\_\_

Telephone day: \_\_\_\_\_

Telephone night: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Could you please provide us with the name and address of three people we could contact to obtain a forwarding address for you if you were to move?

- No (go to question 15)  
 Yes (please fill in details below)

**11. Contact 1**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship \_\_\_\_\_

**12. Contact 2**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship \_\_\_\_\_

**13. Contact 3**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship \_\_\_\_\_

**General Practitioner (GP)**

*Please state the details of your child's usual G.P.*

14. Who is your child's GP? \_\_\_\_\_

15. What is the address of his/her surgery? \_\_\_\_\_  
\_\_\_\_\_

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

***This section has questions relating to your child's hearing and vision. The questions are important because certain hearing and eye conditions can affect your child's schooling. Basic hearing tests can be performed by a doctor or nurse. A detailed hearing test is performed by an audiologist (hearing practitioner) and a report is given to you.***

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

- No (go to question 27)       Unsure (go to question 27)  
 Yes

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

21. Did you receive a report?

- No       Unsure  
 Yes

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

- No       Unsure  
 Yes

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

- No       Unsure  
 Yes

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

- No (go to question 27)       Unsure (go to question 27)  
 Yes

If yes, the problem was? \_\_\_\_\_

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

26. Which ear was involved?

- Right ear       Left ear  
 Both ears       Unsure

***In the past, your child may have had an eye test. This could have been part of a screening program at school, performed by a nurse or orthoptist, or a detailed eye examination by a medical eye specialist (ophthalmologist) or optometrist.***

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

- No (go to question 37)       Unsure (go to question 37)  
 Yes

28. If yes, what age? \_\_\_\_\_ Who performed the test? \_\_\_\_\_



**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)**

38. How long has it been since your child last consulted an eye specialist or optometrist?

- Never (go to question 42)       2 to less than 5 years  
 Less than 1 year       5 years or more  
 1 to less than 2 years       Don't Know (go to question 42)

39. Does your child attend regular eye examinations?

- No       Unsure  
 Yes

40. If yes, please fill in the details of the eye practitioner below. If you are unsure about the type of practitioner he/she is, tick the box marked "other" and state the name and suburb.

**Ophthalmologist (Medical Eye Specialist)**      \_\_\_\_/\_\_\_\_/\_\_\_\_ (date last seen)

Name: \_\_\_\_\_ Suburb: \_\_\_\_\_

**Optometrist**      \_\_\_\_/\_\_\_\_/\_\_\_\_ (date last seen)

Name: \_\_\_\_\_ Suburb: \_\_\_\_\_

**Orthoptist**      \_\_\_\_/\_\_\_\_/\_\_\_\_ (date last seen)

Name: \_\_\_\_\_ Suburb: \_\_\_\_\_

**Other**      \_\_\_\_/\_\_\_\_/\_\_\_\_ (date last seen)

Name: \_\_\_\_\_ Suburb: \_\_\_\_\_

41. Please tick how often the eye practitioner is seen (refer to the eye practitioner that the child sees most often)

- More than once in 6 months       Once a year  
 Every 6 months       Less frequently than once a year

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

- No (go to question 45)  
 Glasses  
 Contact lenses

43. How often are the glasses or contact lenses used?

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

44. What sight problems do your child's glasses or contact lenses correct or partially correct? (*You may tick more than one box*)

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

45. Has your child worn glasses or other optical correction such as contact lenses **in the past**?

- No (go to question 49)                       Unsure (go to question 49)
- Yes

If yes, please state the date and age when prescribed \_\_\_\_\_

Date stopped:   /      
(month) (year)

Reason stopped \_\_\_\_\_

46. How often did your child use their glasses / contact lenses?

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

***We would like to know what glasses were previously prescribed. There are two ways we can find out this information. Firstly, by looking at your child's old glasses during his/her examination at school, OR, by viewing the prescription that the eye specialist / optometrist wrote out.***

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

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

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

- No                                       Unsure  
 Yes

If yes, please attach the prescription or a copy of it to this page in the space provided below. Alternatively, you may write it down with the date it was prescribed:

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

*(Attach prescription here)*

49. Has your child ever had any one or more of the following treatments for myopia (short-sightedness)?

- Bifocals
- Progressive lenses
- Atropine eye drops
- None of the above
- Don't know

50. Has your child ever worn an eye patch?

- No  Unsure
- Yes

If yes, for how long? \_\_\_\_\_

51. Have you ever been told by a doctor or optometrist that your child has a strabismus (turned or lazy eye)?

- No (go to question 53)  Unsure (go to question 53)
- Yes

52. Has your child received treatment for this condition?

- No  Unsure
- Yes (please describe) \_\_\_\_\_

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

- No (go to question 55)  Unsure (go to question 55)
- Yes

If yes, explain the injury (please describe) \_\_\_\_\_

\_\_\_\_\_

54. Do you feel your child's vision was affected by the injury?

- No  Unsure
- Yes

55. Has your child ever had eye surgery?

- No
- Yes (If yes, what was it for? Please tick)
  - Strabismus (turned eye or lazy eye)*
  - Other (please describe)* \_\_\_\_\_

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

- No  Unsure  
 Yes

If yes, please write down the name of all eye drops/ointments **currently** used.

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

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

- No  Unsure  
 Yes

If yes, please write down the name of all eye drops/ointments **previously** used.

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

***Your child may have never been diagnosed with an eye condition, however we would like to know about any concerns you or others might have with his/her eyes or vision.***

58. Has your child ever complained of any eye or vision problems in the past?

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

59. Please tick below all symptoms experienced by your child:

- Blurred vision when looking in the distance  Double vision  
 Sore eyes (how often?) \_\_\_\_\_  
 Other (please describe) \_\_\_\_\_

60. Does your child experience a headache when reading or doing close work?

- No (go to question 63)  Unsure (go to question 63)  
 Yes

61. If yes, how often? \_\_\_\_\_ and at what time of the day? (e.g. 2:30 pm) \_\_\_\_\_

62. How long do the headache symptoms last? (e.g. 30 min)  /    
 (hours) (minutes)

63. Has anyone ever thought there might be a problem with your child's eyesight?  
 No (go to question 65)     Unsure (go to question 65)  
 Yes
64. What was thought to be wrong with his/her eyes?  
 Squint (eyes not looking in same direction)     Don't know  
 Colour blind  
 Something else (please describe) \_\_\_\_\_
65. Do you think your child might need to wear glasses?  
 No     Unsure  
 Yes (please give the reason) \_\_\_\_\_
66. Have you noticed your child to have a turned or lazy eye?  
 No (go to question 70)     Unsure (go to question 70)  
 Yes
67. What age was your child when you first noticed this?   years   months
68. Which eye was affected?  
 Right eye     Left eye
69. 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

## General Medical Details

*This section will ask you questions relating to your child's general medical health. We are interested in both past and current medical conditions, and medicines that your child may have taken. A chronic illness or disability is a condition that has been detected in the past and is currently still ongoing, requiring treatment.*

70. Has your child ever been diagnosed with a chronic illness or disability?  
 No (go to question 75)     Unsure (go to question 75)  
 Yes
71. What was the nature of the illness or disability? (Please name or describe) \_\_\_\_\_  
 \_\_\_\_\_
72. Does your child still have this condition?  
 No     Unsure  
 Yes

73. Does your child receive treatment for this condition?

- No (go to question 75)     Unsure (go to question 75)  
 Yes

74. Please tick the treatment(s) given:

- Medicine prescribed     Surgery     Given injections  
 Physiotherapy     Speech therapy     Dental treatment  
 Naturopathy     Chiropractic treatment  
 Homeopathic treatment     Counselling / guidance  
 Other (please describe) \_\_\_\_\_

**Questions 75 to 81 refer to a condition that has been detected for the first time in the last 2 weeks.  
For example, the flu.**

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

- No (go to question 82)     Unsure (go to question 82)  
 Yes

If yes, what was the reason that you took your child to the doctor? (Please describe) \_\_\_\_\_

76. Was any treatment given?

- No (go to question 82)     Unsure (go to question 82)  
 Yes

77. Please tick the treatment(s) given:

- Medicine prescribed     Surgery performed or recommended  
 Referred to another practitioner (specify) \_\_\_\_\_  
 Other (specify) \_\_\_\_\_

78. Has your child had a second reason to visit a doctor during the last 2 weeks?

- No (go to question 82)     Unsure (go to question 82)  
 Yes

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

80. Was any treatment given?

- No (go to question 82)     Unsure (go to question 82)  
 Yes

81. Please tick the treatment(s) given:

- Medicine prescribed                       Surgery performed or recommended  
 Referred to another practitioner/ doctor  
 Other (please describe) \_\_\_\_\_

**Questions 82 – 89 refer to an illness that was severe enough to require your child’s admission into hospital or day surgery. For example, appendicitis.**

82. Has your child had a major illness in the past that has required admission to hospital or day surgery?

- No (go to question 90)                       Unsure (go to question 90)  
 Yes

83. Please describe the reason for your child’s admission? \_\_\_\_\_

\_\_\_\_\_

84. At what age did this occur? \_\_\_\_\_

85. Did your child have surgery?

- No (go to question 87)                       Unsure (go to question 87)  
 Yes

86. Please name or describe the **surgical procedure** \_\_\_\_\_

87. What was the name of the hospital and in which suburb was it located? \_\_\_\_\_

\_\_\_\_\_

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

- No (go to question 90)                       Unsure (go to question 90)  
 Yes

89. 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: \_\_\_\_\_

***We wish to ask about any medications that your child is currently using, these include both prescribed and non-prescribed medications. Please note that vitamins, inhaled medicines, skin lotions, eye-drops, laxatives, homeopathic and herbal remedies should also be included.***

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

- No (go to question 91)                       Unsure (go to question 91)  
 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					
5					

91. 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:***

- 1) Prescribed medication in Table A;***
- 2) Non-prescribed medication in Table B.***

92. **TABLE A: 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	Age at time
1						
2						
3						
4						
5						

93. **TABLE B: Please list all medications which were purchased over the counter (that is, 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	Age at time
1						
2						
3						
4						
5						

*We would like to ask you about common medical conditions. Certain conditions have proven 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 get asthma?

- No                                     Unsure  
 Yes

96. Do you (the mother) smoke?

- No  
 Yes

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

- No  
 Yes

If you answered *Yes* to *Questions 96 or 97*, please complete the table below.

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

98. 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) \_\_\_\_\_

99. Has your child experienced any difficulties with learning at school or pre-school?

- No  Unsure  
 Yes

If yes, please describe \_\_\_\_\_

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

- No (go to question 103)  Unsure (go to question 103)  
 Yes

101. 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

102. Is your child receiving treatment for this disorder?

- No  Unsure  
 Yes

103. Has your child ever been diagnosed with any of the following? (Please tick)

- Epilepsy  Meningitis  
 Marfan Syndrome  Down Syndrome  
 Stickler Syndrome  Diabetes  
 Toxoplasmosis  
 Other (please describe) \_\_\_\_\_

## Birth History

### Gestation and neo-natal.

*The following questions are about your child's birth and early years.*

**If you still have your health record book (the blue/yellow book) it may help to look at it. These books record birth details.**

**Birth Details:** Extract from Personal Child Health Record- TRANSCRIBE FROM:

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

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

No

Yes

105. Delivery Type

Normal

Breech

Caesarean

Vacuum extraction

Forceps

Other

Don't know

106. What was your child's birth weight? \_\_\_\_\_ Grams or \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces

107. Birth length \_\_\_\_\_ cms

108. Birth head circumference \_\_\_\_\_ cms

109. What was your child's gestation period?   weeks (go to question 111)

Unsure (go to question 110)

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

110. Was your child born

Late (42 weeks or more)

On time (37-41 weeks gestation)

Early (33-36 weeks gestation)

Very early (32 weeks or less)

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

- No  Don't know  
 Yes

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

- No (go to question 114)  Don't know (go to question 114)  
 Yes

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

113. If known, please write down date of discharge.   /   /    
(day) (month) (year)

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

- No, single birth  Don't know  
 Yes, twins  
 Yes, triplets  
 Yes, more than triplets

115. Was your child born:

- In a hospital or birthing centre? (Please name the hospital or birthing centre he/she was born in and the suburb)  
Name of hospital \_\_\_\_\_  
Suburb \_\_\_\_\_ State \_\_\_\_\_
- At home  
 Other (please describe) \_\_\_\_\_

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

- No  
 Yes

117. Has your child ever been breastfed?

- No (go to question 119)  Don't know (go to question 119)  
 Yes

118. 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.***

119. Were there any problems with the pregnancy?

- No
  Unsure  
 Yes (If yes, please describe) \_\_\_\_\_  
 \_\_\_\_\_

120. 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"/>

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

- No (go to question 124)
  Don't Know (go to question 124)  
 Yes

122. 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

123. 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

124. 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 in a day during the pregnancy \_\_\_\_\_

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

No

Unsure

Yes (please write down the names of the medications and for how long they were taken in the table below)

**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					
6					
7					
8					
9					
10					
11					
12					

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

No

Unsure

Yes (please write down the names of the medications and for how long they were taken in the table below)

**Please list all medications which were purchased over the counter (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					
7					
8					
9					
10					
11					
12					
13					
14					
15					

***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.***

127. 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) Playing out of doors (in a backyard, at the park, riding a bike)	<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 (BBQs, picnic, beach, walk)	<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. Playstation	<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 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) Playing with toys, hobby or craft	<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	<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"/>

128. Please tick the activities your child does and the number of *hours per week during the school term* that he/she spends doing the activity. Please also indicate whether this activity is usually done outdoors, in a hall or gym sized room, or in a classroom sized room or smaller.

**DURING THE 7 DAYS OF THE WEEK**

	<b>YES</b>	<b>Number of hours per week spent in this activity</b>	<b>Outdoors</b>	<b>In a hall or gym</b>	<b>In a classroom or smaller</b>
a) Dancing, gymnastics or callisthenics	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Little athletics	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Swimming	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Football, soccer, rugby, league, AFL	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Netball, basketball	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Tennis	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Kanga cricket	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Skating, riding a scooter, rollerblading	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Baseball/ softball	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Attending a youth group/club e.g. cubs, brownies etc	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Attending a religious centre	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Other, please describe below	<input type="checkbox"/>	_____ hrs per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

129. Please list other activities: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Questions about Holidays

*In the last year your child would have had on average about 12 weeks of school holidays. During those weeks, he/she may have spent some considerable time doing different activities at home or in a different location. Please indicate below where and for how long your child spent his/her holidays. More than one box may be ticked.*

130. For the 6 weeks of summer, Christmas holidays

*Duration (if greater than 2 days)*

- |   |       |
|---|-------|
| <input type="checkbox"/> At home, or at a relative's or friend's home for the day | _____ |
| <input type="checkbox"/> In vacation care or at a camp                            | _____ |
| <input type="checkbox"/> Away from home, travelling or in one location            | _____ |
| <input type="checkbox"/> Other (please describe) _____                            | _____ |

131. During these holidays, please estimate the amount of time that your child spent indoors and outdoors during the day.

- Most of the time indoors
- Mainly indoors and occasionally going outdoors for a day, or up to 2 hours outdoors per day
- About equal amounts of time indoors and outdoors
- Mostly outdoors and occasionally spending a day indoors, or up to 2 hours indoors per day
- Most of the time outdoors

132. Describe the activities that your child liked to do most often during these holidays.

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133. The 2 weeks of holidays at the end of term one, the Easter break

*Duration (if greater than 2 days)*

- |   |       |
|---|-------|
| <input type="checkbox"/> At home, or at a relative's or friend's home for the day | _____ |
| <input type="checkbox"/> In vacation care or at a camp                            | _____ |
| <input type="checkbox"/> Away from home, travelling or to stay in one location    | _____ |
| <input type="checkbox"/> Other (please describe) _____                            | _____ |

134. During these holidays, please estimate the amount of time that your child spent indoors and outdoors during the day.

- Most of the time indoors
- Mainly indoors and occasionally going outdoors for a day, or up to 2 hours outdoors per day
- About equal amounts of time indoors and outdoors
- Mostly outdoors and occasionally spending a day indoors, or up to 2 hours indoors per day
- Most of the time outdoors

135. Describe the activities that your child liked to do most often during these holidays.

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136. The 2 weeks of holidays at the end of term two, the winter holidays

*Duration (if greater than 2 days)*

- At home, or at a relative's or friend's home for the day \_\_\_\_\_
- In vacation care or at a camp \_\_\_\_\_
- Away from home, travelling or to stay in one location \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

137. During these holidays, please estimate the amount of time that your child spent indoors and outdoors during the day.

- Most of the time indoors
- Mainly indoors and occasionally going outdoors for a day, or up to 2 hours outdoors per day
- About equal amounts of time indoors and outdoors
- Mostly outdoors and occasionally spending a day indoors, or up to 2 hours indoors per day
- Most of the time outdoors

138. Describe the activities that your child liked to do most often during these holidays.

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139. The 2 weeks of holidays at the end of term three, these include the October long weekend.  
*Duration (if greater than 2 days)*
- At home, or at a relative's or friend's home for the day \_\_\_\_\_
  - In vacation care or at a camp \_\_\_\_\_
  - Away from home, travelling or to stay in one location \_\_\_\_\_
  - Other, please specify \_\_\_\_\_

140. During these holidays, please estimate the amount of time that your child spent indoors and outdoors during the day.
- Most of the time indoors
  - Mainly indoors and occasionally going outdoors for a day, or up to 2 hours outdoors per day
  - About equal amounts of time indoors and outdoors
  - Mostly outdoors and occasionally spending a day indoors, or up to 2 hours indoors per day
  - Most of the time outdoors

141. Describe the activities that your child liked to do most often during these holidays.

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**Near/distance work questions.**

142. Can your child read independently?
- No
  - Yes
  - Unsure

143. Please tick one of the following
- Someone reads to my child on a regular basis (almost every night)
  - Someone reads to my child often
  - Someone reads to my child occasionally
  - Someone reads to my child infrequently

144. How many books or magazines does your child finish reading in a week?
- books or magazines per week

145. How often does he/she borrow books from a library?

- Never
- Less than once a week
- Around once a week
- More than once a week

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

- No (go to question 148)
- Unsure (go to question 148)
- Yes

147. If your child's reading/writing distance is abnormally 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

148. Does your child use a mobile phone either to make calls or play games on?

- No
- Unsure
- Yes

149. When your child is watching TV, how close to the T.V 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)

150. When your child plays video games, like Playstation, how close to the screen does he/she 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)

151. What is your child's main method of transport to school?

- Car
- Train/bus
- Walking
- Other (please describe) \_\_\_\_\_

152. How many minutes does it take **one way** for your child to get to school?

minutes

153. If your child is driven to and from school, what activity is he/she most likely to do during the journey?

Read a book  Talk to other people in the vehicle

Play hand held games  Sleep

Look outside the window

Other (please describe) \_\_\_\_\_

154. Did your child attend preschool?

No (go to question 156)  Unsure (go to question 156)

Yes

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

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

156. Has your child had any periods of prolonged absence from school **due to ill health, travel or any other reason**?

No (go to question 159)  Unsure (go to question 159)

Yes (please give details below)

157. If yes, how many days or weeks? \_\_\_\_\_ Reason for absence: \_\_\_\_\_

158. Please tick when the absence occurred:

Preschool

Kindergarten

Grade 1

159. How many days was your child absent from school in the last year?

Up to 5 days

6 – 20 days

More than 20 days

160. Does your child receive any tutorials, coaching or community classes outside school hours?

No  Unsure

Yes

If yes, please state how many hours per week.    
(hours)

## ABOUT YOUR FAMILY

*This section will ask about your child's biological (natural) parents and family members to identify genetic associations. Children with parents who are myopic are more likely to develop myopia. In addition, 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

161. 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) \_\_\_\_\_

162. Country of birth of both biological parents?

Mother \_\_\_\_\_  Tick if unsure

Father \_\_\_\_\_  Tick if unsure

163. 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) \_\_\_\_\_

164. Date of Birth of the biological mother:

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

165. Please tick all medical conditions the child's biological mother may have had or currently have?

- |  |  |                                 |
|--|--|---------------------------------|
| <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) _____ |                                 |

166. Date of birth of the biological father:

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

167. Please tick all medical conditions the child's biological father may have had or currently have?

- |  |  |                                 |
|--|--|---------------------------------|
| <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

168. 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<br>_____ | <input type="checkbox"/> Stickler syndrome<br>_____ |
| <input type="checkbox"/> Noonan syndrome<br>_____   | <input type="checkbox"/> Down syndrome<br>_____     |
| <input type="checkbox"/> Turner's syndrome<br>_____ | <input type="checkbox"/> Unsure<br>_____            |

169. Please state whether anyone in your child's biological mother's family has had a cataract operation?

*(Age when surgery first performed)*

- Mother \_\_\_\_\_
- Mother's father \_\_\_\_\_
- Mother's mother \_\_\_\_\_
- Mother's brothers \_\_\_\_\_
- Mother's sisters \_\_\_\_\_
- Unsure \_\_\_\_\_

170. Is there anyone in your child's biological mother's family with any other eye condition?

*(Condition)*

- Mother \_\_\_\_\_
- Mother's father \_\_\_\_\_
- Mother's mother \_\_\_\_\_
- Mother's brothers \_\_\_\_\_
- Mother's sisters \_\_\_\_\_
- Unsure \_\_\_\_\_

171. Please state whether anyone in your child's biological father's family has had a cataract operation?

*(Age when surgery first performed)*

- Father \_\_\_\_\_
- Father's father \_\_\_\_\_
- Father's mother \_\_\_\_\_
- Father's brothers \_\_\_\_\_
- Father's sisters \_\_\_\_\_
- Unsure \_\_\_\_\_

172. Is there anyone in your child's biological father's family with any other eye condition?

*(Condition)*

- Father \_\_\_\_\_
- Father's father \_\_\_\_\_
- Father's mother \_\_\_\_\_
- Father's brothers \_\_\_\_\_
- Father's sisters \_\_\_\_\_
- Unsure \_\_\_\_\_

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

Males     Females

174. 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	Place of birth	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

175. Do any of your children living in the household have any known eye problems?  
Please list:

Name	Eye Problem

176. 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 <i>If no, please move on to the next child</i>		<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 <i>If no, please move on to the next child</i>		<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 <i>If no, please move onto the next child</i>		<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 <i>If no, please move on to the next child</i>		<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 <i>If no, please move on to the next child</i>		<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 <i>If no, please move on to the next child</i>		<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.***

177. Please fill out the tables with reference to your child's biological family members. As a guide: indicate in the second column whether any family member has ever worn glasses or contact lenses. If your answer is No, then go to the next relative on the row below. If your answer is yes, please fill out the rest of the information in the row.

<b>Family members</b>	<b>Do they wear glasses or contact lenses?</b>	<b>At what age did they start wearing glasses?</b>	<b>What do they wear glasses or contact lens primarily for?</b>	<b>Do they have astigmatism?</b>
1. Father	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <i>If no, please move on to next family member</i>		<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 <i>If no, please move on to next family member</i>		<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 <i>If no, please move on to next family member</i>		<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 <i>If no, please move on to next family member</i>		<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 <i>If no, please move on to next family member</i>		<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 <i>If no, please move on to next family member</i>		<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

178. Has anyone in your family had refractive surgery?

No (go to question 181)

Yes

179. If yes, what is his or her relation to the child (e.g., father, sister) \_\_\_\_\_

180. 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**

181. Parents' occupation(s):

Mother's Occupation: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Current Occupation \_\_\_\_\_

182. 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 \_\_\_\_\_

183. 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 \_\_\_\_\_

184. 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 - 4<sup>th</sup> Form
- Completed HSC - Year 12 – Leaving - 6<sup>th</sup> Form
- TAFE Certificate or Diploma, including trade certificate
- University, CAE or some other tertiary institute degree
- Higher degree including a Masters or PhD
- Other \_\_\_\_\_

185. 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 - 4<sup>th</sup> Form
- Completed HSC - Year 12 – Leaving - 6<sup>th</sup> Form
- TAFE Certificate or Diploma, including trade certificate
- University, CAE or some other tertiary institute degree
- Higher degree including a Masters or PhD
- Other \_\_\_\_\_

186. What sort of a 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) _____ |   |

***Please answer these questions about your child's home. This information will be used to study whether a child's dwelling affects development.***

187. Please tick the box that best describes the dwelling structure your child lives in:

- Separate house
- Semi-detached, row or terrace house with:
  - One story*
  - Two or more stories*
- Flat attached to a house
- Other flat/unit/apartment:
  - In a 1 or 2 storey block*
  - In a 3 storey block*
  - In a 4 or more storey block*
- Caravan/tent/cabin in a caravan park, houseboat in a marina, etc.
- Caravan not in a caravan park/houseboat not in a marina, etc.
- Improvised home/campers out
- House or flat attached to a shop, office, etc.

188. Does your child live regularly in another dwelling structure for 2 days or more per week on average?

- No (go to question 190)
- Yes

189. If yes, please tick the box that best describes the dwelling structure your child lives in regularly for greater than two days per week:

- Separate house
- Semi-detached, row or terrace house with:
  - One story*
  - Two or more stories*
- Flat attached to a house
- Other flat/unit/apartment:
  - In a 1 or 2 storey block*
  - In a 3 storey block*
  - In a 4 or more storey block*
- Caravan/tent/cabin in a caravan park, houseboat in a marina, etc.
- Caravan not in a caravan park/houseboat not in a marina, etc.
- Improvised home/campers out
- House or flat attached to a shop, office, etc.

### **Greenspace Questions**

190. From the front door of your dwelling, how many other residential dwellings can you see?

- Less than 5
- 5-10
- Greater than 10
- Unsure

191. From the front door of your dwelling, how many commercial buildings can you see?

- None (go to question 193)
- Less than 5
- Greater than 5
- Unsure (go to question 193)

192. Of these, how many high rise buildings, including apartments, flats and offices are included?

- None
- Less than 5
- Greater than 5
- Unsure

193. Is it possible to get a view of the horizon from the ground floor of your dwelling?

- No
- Yes
- Unsure

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 \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

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