

TELEPHONE INTERVIEW

1. Identity

- 1-1 {Idnum} ID number
- 1-2 {idhosp} Blue Mountains Hospital No.....
- 1-3 {idwmh} Westmead Hospital No.....
- 1-4 {surname} Surname
- 1-5 {name} First name (s)
- 1-6 {sex} Sex: Female 1 Male 2
- 1-7 {DOB} Date of birth/...../.....
- 1-8 {address} Your current address?
.....
.....
- 1-9 {postcode} Postcode
- 1-10 {usuadr} Is this your usual address (live here more than 6 months of the year)? Y 1 N 2
- 1-11 {phno} Your phone number?
- 1-12 {othadd} Do you have another address? Y 1 N 2 DK 8 Missing 9
- 1-13 {addoth} **If yes**, other address:.....
.....
- 1-14 {postoth} Postcode
- 1-15 {private} Are you a member of a private health fund? Y 1 N 2 DK 8 Missing 9
- 1-16 {yrsBM} How long have you lived in the Blue Mountains?years DK 8 Missing 9
- 1-17 {marital} What is your **current marital status**?
- | | | | |
|---------------------------------|----------------------------|----------------|----------------------------|
| never married | <input type="checkbox"/> 1 | divorced | <input type="checkbox"/> 4 |
| married..... | <input type="checkbox"/> 2 | widowed | <input type="checkbox"/> 5 |
| separated but not divorced..... | <input type="checkbox"/> 3 | DK | <input type="checkbox"/> 8 |
| | | missing | <input type="checkbox"/> 9 |
- 1-18 {fammem} Have we seen any of your family members previously in the Eye Study?
Y 1 N 2 DK 8 Missing 9
- 1-19 {famname} **If yes**, who (name and relationship)
- Person 1..... {rel1typ} relationship.....
- Person 2..... {rel2typ} relationship

For person 1

1-20 {1f/u} Has or will he/she been seen in the 10-year follow up study?
Y 1 N 2 DK 8 Missing 9

1-21 {1nof/u} **If no**, do you know why he/she has not returned?
..... | code.....

1-22 {1famdod} **If deceased**, do you know the date of his/ her death?/...../.....

For person 2

1-23 {2f/u} Has or will he/she been seen in the 10-year follow up study?
Y 1 N 2 DK 8 Missing 9

1-24 {2nof/u} **If no**, do you know why he/she did not return?
..... | code.....

1-25 {2famdod} **If deceased**, do you know the date of his/ her death?/...../.....

1-26 {elig} Is anyone else in your household eligible for the Study (i.e. aged 50 or older and has not previously participated in the Study)? Y 1 N 2 DK 8 Missing 9

1-27 {othcome} **If yes**, do you think he would be interested in participating at a later date?
Y 1 N 2 DK 8 Missing 9

1-28 {notcome} **Name and contact details?**
.....
.....

Could you please give us the name and addresses of two people we could contact to get a forwarding address for you if you move?

Contact 1

1-29 {fadnam1} Name.....

1-30 {fadph1} Telephone.....

1-31 {fadd1} Address.....
.....

1-32 {fadrell} Relationship.....

Contact 2

1-33 {fadnam2} Name.....

1-34 {fadph2} Telephone.....

1-35 {fadd2} Address.....
.....

1-36 {fadrel2} Relationship.....

3. Social Information

3-1 {pension} Do you receive a **pension**? Y 1 N 2 **go to 3-3** DK 8 Missing 9

3-2 {sort} **If yes, what sort of a pension?**
 age..... 1 other..... 5 **specify**.....
 invalid..... 2
 veteran's... 3 DK 88
 blind..... 4 missing..... 99

3-3 {other\$} Are you receiving other income or superannuation?
Y 1 N 2 DK 8 Missing 9 refused 3

The next question concerns your current income and is identical to the income question in the 2001 Census. All information you provide is confidential. However, as these questions involve personal details, which you may not wish to disclose, you can choose not to answer this question if you wish.

3-4 {Sinc} What was the gross income (including pensions and allowances) that you receive each week from all sources?
 (count all income including: family allowance, parenting payment, unemployment benefits, rental assistance, pensions, student allowance, maintenance (child support), worker's compensation, superannuation, wages, salary, overtime, commissions and bonuses, interest received, dividends, rents received (less expenses of operation), business or farm income (less expenses of operation). Do not deduct tax, superannuation, health insurance).

- \$1,000 or more per week (\$52,000 or more per year)... 1
- \$700 - 999 per week (\$36,400 - \$51,599 per year)..... 2
- \$400 - 699 per week (\$20,800 - \$36,399 per year)..... 3
- \$200 - 399 per week (\$10,400 - \$20,799 per year)..... 4
- \$160 - 199 per week (\$8,320 - \$10,399 per year)..... 5
- \$120 - 159 per week (\$6,240 - \$8,319 per year)..... 6
- \$1 - 119 per week (\$1 - \$6,239 per year)..... 7
- Nil income..... 8
- Negative income..... 9
- Don't know..... 88
- Refused..... 99

3-5 {Sdetail1} source 1:..... | code.....

3-6 {Sdetail2} source 2:..... | code.....

3-7 {abode} What sort of a place do you live in?
 own house 1 nursing home 7
 own flat/unit 2 with relatives 8
 rented house 3 other 9 **specify**.....
 rented flat 4 DK 88
 hostel 5 missing 99
 boarding house 6

- 3-8 {wholive} Who lives with you? (multiple answers possible)
- | | | | |
|-----------------------|----------------------------|---------------|--|
| nobody | <input type="checkbox"/> 1 | friend | <input type="checkbox"/> 6 |
| spouse | <input type="checkbox"/> 2 | pets | <input type="checkbox"/> 7 specify type |
| partner..... | <input type="checkbox"/> 3 | other..... | <input type="checkbox"/> 8 specify |
| daughter..... | <input type="checkbox"/> 4 | | |
| son | <input type="checkbox"/> 5 | DK..... | <input type="checkbox"/> 88 |
| other relatives | <input type="checkbox"/> 6 | missing | <input type="checkbox"/> 99 |

Do you get regular help at home from?

- | | yes | no | DK | missing | |
|------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|--|
| 3-9 {mow} Meals on Wheels | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | If yes, no. of visits..... per week |
| 3-10 {nurse} community nurse | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | If yes, no. of visits per week |
| 3-11 {hmhelp} Home Care | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | If yes, no. of visits per week |
| 3-12 {othhelp} others | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | If yes, specify
no. of visits per week |

- 3-13 {cleanhs} Who usually cleans your house?
- | | | | |
|-----------------------|----------------------------|---------------|---|
| you | <input type="checkbox"/> 1 | friend | <input type="checkbox"/> 6 |
| spouse/ partner..... | <input type="checkbox"/> 2 | others | <input type="checkbox"/> 7 specify |
| daughter | <input type="checkbox"/> 3 | DK..... | <input type="checkbox"/> 8 |
| son | <input type="checkbox"/> 4 | missing | <input type="checkbox"/> 9 |
| other relatives | <input type="checkbox"/> 5 | | |

- 3-14 {whoshop} Who usually does your shopping?
- | | | | |
|-----------------------|----------------------------|---------------|---|
| you | <input type="checkbox"/> 1 | friend | <input type="checkbox"/> 6 |
| spouse/ partner..... | <input type="checkbox"/> 2 | others | <input type="checkbox"/> 7 specify |
| daughter | <input type="checkbox"/> 3 | DK..... | <input type="checkbox"/> 8 |
| son | <input type="checkbox"/> 4 | missing | <input type="checkbox"/> 9 |
| other relatives | <input type="checkbox"/> 5 | | |

Are you able to go out alone....?

- 3-15 {goshop} to do the shopping Y 1 N 2
- 3-16 {govisit} to visit someone Y 1 N 2
- 3-17 {gotown} to go to 'town' Y 1 N 2

4. Check whether this collected previously

4-1 {birthpl} Where were you **born**?..... | code.....
(write state or territory if in Australia, country if overseas)

4-2 {ageAust} **If not born in Australia**, how old were you when you first came to Australia?
..... years old DK 8 Missing 9

4-3 {mumborn} Where was your **mother born**?..... | code.....
(write state or territory if in Australia, country if overseas)

4-4 {dadborn} Where was your **father born**?..... | code.....
(write state or territory if in Australia, country if overseas)

4-5 {race} Racial group: *examiner to fill in, ask only if unsure*

White	<input type="checkbox"/> 1	Oceanian	<input type="checkbox"/> 5
Aboriginal	<input type="checkbox"/> 2	Asian	<input type="checkbox"/> 6
Negroid.....	<input type="checkbox"/> 3	Indian	<input type="checkbox"/> 7
Hispanic	<input type="checkbox"/> 4	Mixed.....	<input type="checkbox"/> 8 Specify.....

4-6 {speak} At home do you speak a language other than English?
Y 1 N 2 DK 8 Missing 9

4-7 {spoken} **If yes**, What language do you speak? | code.....

4-8 {medica} If not obtained: Medicare number --

Medications

I would like to ask about the tablets, vitamins or other medications you are currently taking.
 May I see the medications you are taking now? (Request to show plastic BMES3 medication bag)
 Please complete as accurately as possible.

5. Present Medications

5-0 {curmed} Are you currently taking any medications?
 Y ₁ N ₂ **go to 6-0** DK ₈ Missing ₉

	Name	code	strength (mg) per tablet	no. of tablets /day	duration (months)
5-1 {tab1}					
5-2 {tab2}					
5-3 {tab3}					
5-4 {tab4}					
5-5 {tab5}					
5-6 {tab6}					
5-7 {tab7}					
5-8 {tab8}					
5-9 {tab9}					
5-10 {tab10}					
5-11 {tab11}					
5-12 {tab12}					

Medication List
(please attach securely)

A large, empty rectangular box with a black border, occupying most of the page. It is intended for the user to provide a medication list, as indicated by the text above it.

6. Past Medications

6-0 {pastcur} Can you recall any other tablets, vitamins, drops, or other medications that you are not taking now that you have taken for more than 3 months in the past?

Y 1 N 2 go to 7-0 DK 8 Missing 9

If yes, request to see list prepared (sent with confirmation of appointment)

	Name	code	strength (mg)	no./day	duration (months)
6-1 {tabp1}					
6-2 {tabp2}					
6-3 {tabp3}					
6-4 {tabp4}					
6-5 {tabp5}					
6-6 {tabp6}					
6-7 {tabp7}					
6-8 {tabp8}					

7. Eyedrop Medications

7-0 {eyemed} Are you currently using any eyedrops for any eye conditions?

Y 1 N 2 go to 8-1 DK 8 Missing 9

	Name	yes	no	DK	missing	code	strength (%)	drops/day	duration (months)
7-1 {drop1}	Timolol	1	2	8	9	N/A			
7-2 {drop2}	Xalatan	1	2	8	9	N/A			
7-3 {drop3}	Artificial tears	specify.....							
7-4 {drop4}	other	specify.....							
7-5 {drop5}	other	specify.....							
7-6 {drop6}	other	specify.....							

8. Specific Medications

Aspirin

I am now going to ask questions about your use of aspirin.

Aspirin-based drugs include: solprin, cardiprin, disprin, ecotrin, **but not panadol or dymadon.**

8-1 {aspirin} Have you taken aspirin in the last 12 months?
 Y 1 N 2 **go to 8-4** DK 8 Missing 9

8-2 {aspmon} **If yes**, how many aspirin would you typically consume per month?
 tablets per month.....

8-3 {aspyr} For how many years have you been taking this amount?.....yrs

Steroids

8-4 {stmed} Have you ever taken steroid **tablets** such as Prednisone for asthma, arthritis or other conditions for more than one month? Y 1 N 2 **go to 8-8** DK 8 Missing 9

If yes, which tablets?

	Name	yes	no	DK	missing	code	strength (mg)	no./day	duration (months)
8-5 {spec1}	Prednisone	1	2	8	9	N/A			
8-6 {spec2}	Other	specify.....							

8-7 {spec3} What condition were you taking steroid tablets for?

..... | code.....

8-8 {stinmed} Have you ever used any steroid inhalers for **more than one month** in the form of nasal sprays, puffers, turbuhalers or nebulisers? This does not include ventolin, intal or Bricanyl.
 Y 1 N 2 **go to 8-22** DK 8 Missing 9

If yes, have you taken....

	Name	yes	no	don't know	missing	strength mg	Puffs /day	duration (months)
8-9 {spec4}	Beconase (nasal spray for hay fever)	1	2	8	9			
8-10 {spec5}	Becloforte puffer (yellow), without spacer	1	2	8	9			
8-11 {spec6}	Becloforte puffer (yellow), with spacer	1	2	8	9			
8-12 {spec7}	Becotide puffer (brown), without spacer	1	2	8	9			
8-13 {spec8}	Becotide (brown), with spacer	1	2	8	9			
8-14 {spec9}	Pulmicort turbuhaler (white, makes a clicking noise)	1	2	8	9			
8-15 {spec10}	Pulmicort puffer (brown), without spacer	1	2	8	9			
8-16 {spec11}	Pulmicort puffer (brown), with spacer	1	2	8	9			

	Name	yes	no	don't know	missing	strength mg	Puffs /day	duration (months)
8-17 {spec12}	Pulmicort via a nebuliser, with a mask	1	2	8	9			
8-18 {spec13}	Pulmicort via a nebuliser, with a mouthpiece	1	2	8	9			
8-19 {spec14}	Flixotide puffer (orange)	1	2	8	9			
8-20 {spec15}	Aldecin puffer (white/maroon)	1	2	8	9			
8-21 {spec16}	Other: specify ..... | code.....	N/A						

Antidepressants

8-22 {spec28} Have you ever taken tablets for depression? Y 1 N 2 DK 8 Missing 9

Have you ever taken any of the following tablets?

	Name	yes	no	DK	missing	code	strength (mg)	Freq.	duration (months)
8-23 {spec17}	Zoloft (sertraline)	1	2	8	9	N/A			
8-24 {spec18}	Prozac, Erocip, Auscap, Fluohexal, Lovan, Zactin (fluoxetine)	1	2	8	9	N/A			
8-25 {spec19}	Aropax (paroxetine)	1	2	8	9	N/A			
8-26 {spec20}	Cipramil (citalopram)	1	2	8	9	N/A			
8-27 {spec21}	Luvox (fluvoxamine)	1	2	8	9	N/A			
8-28 {spec22}	Endep, Tryptanol (amitriptyline)	1	2	8	9	N/A			
8-29 {spec23}	Other	specify.....							

B12 and Folate

8-30 {medb123} Do you have **B12 (Neocytamen) injections**? Y 1 N 2 **go to 8-33** DK 8 Missing 9

8-31 {b12freq} **If yes**, how often do you receive them?months

8-32 {b12yr} how many years have you been receiving them?years

8-33 {folmed3} Have you been taking **folate** tablets? Y 1 N 2 **go to 9-1** DK 8 Missing 9

8-34 {folfreq} **If yes**, how often do you take them?

8-35 {folyr} how many years have you been taking them?years

10. Medical Conditions

Has a doctor advised you that you have any of the following conditions.....

10-1 {angina} **“angina”?** Y 1 N 2 DK 8 Missing 9

If yes,

10-1.1 {angyr} When was it first diagnosed?years ago

10-1.2 {angeceg} Was the diagnosis confirmed with an ECG? Y 1 N 2 DK 8 Missing 9

10-1.3 {angdr} Name & address of Dr. who made diagnosis?
.....

10-1.4 {angtab} How often do you take anginine tablets or sprays? times per.....

10-2 {mi} **heart attack?** Y 1 N 2 DK 8 Missing 9

If yes,

10-2.1 {miyr} When was it diagnosed?years ago

10-2.2 {miecg} Was the diagnosis confirmed with an ECG? Y 1 N 2 DK 8 Missing 9

10-2.3 {mibld} a blood test? Y 1 N 2 DK 8 Missing 9

10-2.4 {midr} Name & address of Dr. who made diagnosis?
.....

10-2.5 {mihsp} Were you admitted to hospital? Y 1 N 2 DK 8 Missing 9

10-2.6 {mihspnm} Which hospital?.....

10-2.7 {mihspst} For how long?.....days

10-2.8 {mirx} Treatment for your heart attack?

Bypass.....years ago athospital

Angioplasty.....years ago athospital

Pacemakeryears ago athospital

Valve replacementyears ago athospital

Other: specify.....

10-3 {cva} **stroke?** Y 1 N 2 DK 8 Missing 9

If yes,

10-3.1 {cvayr} When was it diagnosed?years ago

10-3.2 {cvaCT} Was the diagnosis confirmed with a **CT scan**? Y 1 N 2 DK 8 Missing 9

10-3.3 {cvadr} Name & address of Dr. who made diagnosis?
.....

10-3.4 {cvahsp} Were you admitted to hospital? Y 1 N 2 DK 8 Missing 9

10-3.5 {cvahspn} Which hospital?.....

10-3.6 {cvahspt} For how long?.....days

10-3.7 {cvaaff} How did the stroke affect you? Mild Moderate Severe

10-3.8 {cvabod} Part of body affected: **Arm** right left **Leg** right left
Speech **Other**

10-3.9 {strkrec3} How well have you recovered from the stroke?.....% (100% is full recovery)

10-3.10 {strkdur3} How long did it take?months

10-3.11 {strkRx3} Treatment for your stroke?

Aspirin, clopidogrel, persantin

Anticoagulation (heparin, clexane and warfarin)

Don't know

Has a doctor advised you that you have any of the following conditions.....

10-4 {tia}	Mini-Stroke or TIA?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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(Stroke-like episodes with weakness in your face, fingers, hands, arms which last for short periods of time
transient loss of vision in one eye)

If yes

10-4.1 {tiayr} When was the first attack? years ago

10-4.2 {tiaop} Did you ever have surgery to the brain or neck to correct or prevent a stroke?
Y 1 N 2 DK 8 Missing 9

10-4.3 {tiahsp} Which hospital did you have this surgery at?.....

10-4.4 {tiaopt} Surgeryyears ago

10-5 {ht}	high blood pressure?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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If yes

10-5.1 {htyr} When was it first diagnosed?years ago

10-5.2 {htmed} for how many years has it been treated with medications?.....years

10-6 {chol}	high cholesterol?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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If yes

10-6.1 {cholyr} When was it first diagnosed?years ago

10-6.2 {choltab} Are you taking tablets? Gemfibrozil (lopid, ausgem)1
Fluvastatin (lescol, vastin)2
Simvastatin (lipex, zocor)3
Other _____6
No 0 DK 8

(Colestipol, Atorvastatin, Cerivastatin, Pravastatin, Probucol, Cholestyramine, Nicotinic Acid)

Has a doctor advised you that you have any of the following conditions.....

10-7 {asth}	asthma?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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If yes

10-7.1 {asthyr} When was it first diagnosed?years ago

10-8 {gout}	gout?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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If yes

10-8.1 {goutyr} When was the first episode of gout?years ago

10-8.2 {goutmed} Are you taking a medicine for gout? Allopurinol 1
Colchicine 2
Probenecid 3
Other _____6
No 0 DK 8

10-9 {arth}	arthritis?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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If yes

10-9.1 {arthyr} When was it first diagnosed?years ago

10-9.2 {arthtyp} Has your doctor told you what type of arthritis it is?..... DK 8 Missing 9

10-10_{ca} Have you been diagnosed with **cancer**? Y 1 N 2 DK 8 Missing 9

If yes

10-10.1 Cancer 1

- a _{ca1yr} year of diagnosis.....
- b _{ca1typ} Type of cancer.....
- c _{ca1rx} Chronological treatment details (plus year).....
.....
- d _{ca1dr} Name and address of Doctor treating you.....
.....

10-10.2 Cancer 2

- a _{ca2yr} year of diagnosis.....
- b _{ca2typ} Type of cancer.....
- c _{ca2rx} Chronological treatment details (plus year).....
.....
- d _{ca2dr} Name and address of Doctor treating you.....
.....

10-10.3 Cancer 3

- a _{ca3yr} year of diagnosis.....
- b _{ca3typ} Type of cancer.....
- c _{ca3rx} Chronological treatment details (plus year).....
.....
- d _{ca3dr} Name and address of Doctor treating you.....
.....

10-11_{skca} Have you ever had sunspots or **skin cancers** treated by either surgery or freezing over the last 12 months only ? Y 1 N 2 DK 8 Missing 9

If yes

10-11.1 _{skcano} how many lesions?lesions

10-12_{thy} **thyroid condition?** Y 1 N 2 DK 8 Missing 9

If yes

10-12.1 _{thyyr} When was it first diagnosed? years ago

10-12.2 _{thydx} What was your thyroid problem due to?specify

10-12.3 _{thyact} At the time of diagnosis, was your thyroid problem....
 underactive overactive normal activity
 DK 8 Missing 9

10-12.4 _{thygoit} Did you have a goitre (enlarged thyroid gland)? Y 1 N 2 DK 8 Missing 9

10-12.5 _{thyrx} Indicate which treatment you received (can tick more than one box):

- Surgery 1 age.....type of surgery
- Radioactive iodine 2 fromyears old for months
- Thyroxine tablets 3 fromyears old to years old still taking
- Carbimazole/ Neo-mercazole (anti-thyroid medication)
4 fromyears old toyears old
- Propylthiouracil 5 from years old toyears old
- no treatment... 7
- DK8 missing.....9

10-12.6 _{thydr} Name and address of Doctors treating your thyroid problem currently?
.....
.....

10-13 {diab}	Do you have Diabetes?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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(High sugar in the blood or urine)

If yes

10-13.1 {diabyr} When was it first diagnosed? years ago

In what year did you begin and finish each type of treatment? (if currently on treatment put 7777 as year finished)

		Yes	No	DK	Miss'g	Started	Finished
10-13.2 {diadiet}	Diet alone	1	2	8	9	.....	.....
10-13.3 {diatab}	Tablets	1	2	8	9	.....	.....
10-13.4 {diains}	Insulin	1	2	8	9	.....	.....
10-13.5 {diabno}	No treatment	1	2	8	9	.....	.....

Has a doctor advised you that you have any of the following conditions.....

10-14 {parkd}	Parkinson disease?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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10-14.1 {parkdx} When was it first diagnosed? years ago

10-15 {kiddx}	Kidney Disease?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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10-15.1 {kiddx} When was this first diagnosed.....years ago

10-15.2 {kideaus} What was it caused by?.....

10-15.3 {kidr} Name and address of treating kidney doctor?

.....

.....

10-15.4 {kidrx} What type of treatment are you receiving?

- None 1
- Dietary measures 2
- Medication 3
- Peritoneal dialysis 4 commencedyears ago athospital
- Haemodialysis 5 commencedyears ago athospital
- Kidney transplant 6years ago athospital
- Other..... 7
- Missing..... 8

10-16 {livdx}	Liver disease	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
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10-16.1 {livdx} When was this first diagnosed.....years ago

10-16.2 {liveaus} What was it caused by?.....

10-16.3 {livdr} Name and address of treating liver doctor?

.....

.....

10-16.4 {livrx} Treatment received?please specify

10-17 Have you had **any other serious illnesses?** Y 1 N 2 DK 8 Missing 9
If yes, specify illness and year:

{illnes1} | code.....**year:**.....
{illnes2} | code.....**year:**.....
{illnes3} | code.....**year:**.....
{illnes4} | code.....**year:**.....
{illnes5} | code.....**year:**.....

10-18 Have you had any **major operations?** Y 1 N 2 DK 8 Missing 9
If yes, specify operation and year:

{surg1} | code.....**year:**.....
{surg2} | code.....**year:**.....
{surg3} | code.....**year:**.....
{surg4} | code.....**year:**.....
{surg5} | code.....**year:**.....

11. Heart and lung symptoms

11-1 {sobflt}	Do you get shortness of breath when you are lying down flat while awake?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2 go to 11-3	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-2 {soborthop}	If yes , does this shortness of breath improve when you sit up, or do you use extra pillows at night to prevent it?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-3 {sobpnd}	Do you get severe shortness of breath that wakes you up while lying down asleep?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-4 {cgham}	Do you usually cough first thing in the morning (on getting up) in the winter?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-5 {cghwint}	Do you usually cough during the day (or at night) in the winter?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-6 {cgh3mo}	If yes 11-4 or 11-5, continue otherwise go to 11-7 Do you cough like this on most days (or nights) for as much as three months each year?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-7 {plgmam}	Do you usually bring up any phlegm from your chest first thing in the morning (on getting up) in the winter?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-8 {plgmbd}	Do you usually bring up any phlegm from your chest at least twice during the day (or at night) in the winter?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-9 {plgm3mo}	If yes 11-7 or 11-8, continue otherwise go to 11-10 Do you bring up phlegm like this on most days (or nights) for as much as three months each year?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-10 {whz}	Does your chest ever sound wheezing or whistling?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-11 {whzdays}	If yes , Do you get this most days (or nights)?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9
11-12 {sobwhz}	Have you ever had attacks of shortness of breath with wheezing?	<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9

12. Sleep Questions

12-1 {snore} Have you ever been told that you snore in your sleep?

Y 1 N 2 DK 8 Missing 9

12-2 {choke} Have you ever been told that you choke or gasp in your sleep at night?

Y 1 N 2 DK 8 Missing 9

12-3 {stpbr} Have you ever been told that you stop breathing during your sleep?

Y 1 N 2 DK 8 Missing 9

12-4 {somi} Do you often feel sleepy during the day?

Y 1 N 2 **go to 12-5** DK 8 Missing 9

If yes, how likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

The Epworth Sleepiness Scale						
	Situation	Chance of dozing				
		None	Slight	Mod	High	NA
12-4.1 {slsit}	Sitting and reading	0	1	2	3	7
12-4.2 {sltv}	Watching T.V	0	1	2	3	7
12-4.3 {slpub}	Sitting inactive in public place (eg theatre or meeting)	0	1	2	3	7
12-4.4 {slcar}	As a passenger in a car for an hour without a break	0	1	2	3	7
12-4.5 {slrest}	Lying down to rest in the afternoon when circumstances permit	0	1	2	3	7
12-4.6 {sltalk}	Sitting and talking to someone	0	1	2	3	7
12-4.7 {sllech}	Sitting quietly after lunch without alcohol	0	1	2	3	7
12-4.8 {sltrf}	In a car, whilst stopped for a few minutes in traffic	0	1	2	3	7

12-5 {som2} Do you feel unfreshed from your sleep? Y 1 N 2 DK 8 Missing 9

12-6 {slapn} Have you been told by a doctor that you have **sleep apnoea**?

Y 1 N 2 **go to 13-1** DK 8 Missing 9

12-7 {slapnyr} **If yes**, for how many years?yrs

12-8 {slapndx} Was the diagnosis confirmed on nocturnal polysomnogram/ sleep study?

Y 1 N 2 DK 8 Missing 9

12-9 {slapndr} Name & Address of doctor who made diagnosis?

.....
.....

12-10 {slapnrx} What treatment have you received and year of treatment?

- Weight reduction 1years ago
- Alcohol reduction 2 years ago
- Surgery 3specify..... years ago
- Nasal CPAP/ Bi PAP 4..... years ago
- Other 5.....specify..... years ago
- DK 8
- Missing 9

13. Migraines

13-1 {migra1n} Has a doctor ever told you that you suffer from migraine?
 (severe headaches, usually on one side, **at least 5 attacks during lifetime, lasting at least 4 hours and less than 3 days**, may have changes in vision like zig-zag lines or blurring, often nausea or vomiting and you usually need to lie down with the lights off)

Y 1 N 2 **go to 14-1** DK 8 **go to 14-1** Missing 9

13-2 {mig1st} Age started.....years old

13-3 {migstop} How old were you when you stopped getting migraines?years old

still getting them 7 DK 8 Missing 9

Check previous questionnaire – complete only if not collected previously or if condition changed

Which of the following have you had with your migraine?

		yes	no	don't know	missing
13-4 {migha}	moderate/severe headaches	1	2	8	9
13-5 {migsd}	on one side of the head	1	2	8	9
13-6 {migpul}	headache has pulsating quality	1	2	8	9
13-7 {migst}	aggravated by walking stairs (or similar routine physical activity)	1	2	8	9
13-8 {migns}	nausea or vomiting	1	2	8	9
13-9 {miglt}	sensitive to light	1	2	8	9
13-10 {migno}	sensitive to noise	1	2	8	9
13-11 {migaur}	Have you experienced an aura with your migraine? (must have occurred at least twice , and usually occurs <1hour before headache , includes visual disturbances, pins and needles or numbness, weakness of one side of body, difficulty with speech)				
		<input type="checkbox"/> Y 1	<input type="checkbox"/> N 2 go to 14-1	<input type="checkbox"/> DK 8	<input type="checkbox"/> Missing 9

Which of the following have you had with your migraine?

		yes	no	don't know	missing
13-12 {migvis}	visual disturbances in both eyes	1	2	8	9
13-13 {migpn}	pins and needles or numbness	1	2	8	9
13-14 {migwk}	weakness of one side of body	1	2	8	9
13-15 {migspe}	difficulty with speech	1	2	8	9

14. Falls and Fractures

General – falls and fractures

14-1 {falls} During the past **12 months**, have you had any falls where you have landed on the ground or floor? Y 1 N 2 **go to 14-4** DK 8 Missing 9

14-2 {fallno} **If yes**, number of falls (during the past 12 months)

14-3 {fallvis} How many of these falls do you think were due to problems with your vision?

14-4 {falffear} Are you afraid of falling? Y 1 N 2 **go to 14-6** DK 8 Missing 9

14-5 {hwfear} How afraid are you of falling?

Little 0

Moderately 1

Very 2

DK 8

14-6 {fract} Have you broken or fractured a bone since your last exam here?

Y 1 N 2 DK 8 Missing 9

If yes, please give details (type of fracture, operation?, name of doctor, hospital, complications):

.....
.....
.....
.....

15. Women's Health

Check previous questionnaire to confirm details

15-1 {meno} When did you stop having periods?
after attending previous study 1
before attending previous study..... 2 **go to 15-4**
still having periods 3 **go to 15-8**

15-2 {menoage} How old were you when you stopped having periods?years old

15-3 {menreas} Did you stop naturally or because of a hysterectomy?
naturally..... 1 other reason..... 3
hysterectomy..... 2 **go to 15-5** don't know 8
missing..... 9

15-4 {hyst} Have you had a hysterectomy? Y 1 N 2 **go to 15-6** DK 8 Missing 9

15-5 {hystage} **If yes**, how old were you when you had a hysterectomy? yrs
 DK 8 Missing 9

15-6 {hystov} Have you had **both** ovaries removed? Y 1 N 2 **go to 15-8** DK 8 Missing 9

15-7 {hystovt} **If yes**, how old were you when you had **both** ovaries removed?..... yrs
 DK 8 Missing 9

15-8 {hrt} Did you take hormone replacement therapy after the menopause or for menopausal symptoms? Y₁ N₂ **go to 15-17** DK₈ Missing₉

If yes, for HRT 1:

15-9 {hrtstt1} When did you start?(year) DK₈ Missing₉

15-10 {hrtfin1} When did you stop?(year) still taking₇ DK₈ Missing₉

15-11 {hrttyp1} Was it estrogen only, or estrogen and progesterone combined?
estrogen only₁ combined₂ (estrogen and progesterone) DK₈ Missing₉

15-12 {hrtname1} What was/is its name | code..... DK₈ Missing₉

for HRT 2:

15-13 {hrtstt2} When did you start?(year) DK₈ Missing₉

15-14 {hrtfin1} When did you stop?(year) still taking₇ DK₈ Missing₉

15-15 {hrttyp1} Was it estrogen only, or estrogen and progesterone combined?
estrogen only₁ combined₂ (estrogen and progesterone) DK₈ Missing₉

15-16 {hrtname1} What was/is its name | code..... DK₈ Missing₉

Pap Smear Test

15-17 {papkno} Have you ever heard of a **Pap Smear Test**? Y₁ N₂ DK₈ Missing₉

A Pap Smear Test, sometimes called a Pap test, is a routine test carried out by a doctor. It is recommended for all women to detect cancer of the cervix.

15-18 {paphad} Have you ever had a Pap Smear Test? Y₁ N₂ **go to 15-20** DK₈ Missing₉

15-19 {papwhen} When did you have your last Pap Smear Test?

Less than 1 year ago..... ₁ 5 or more years ago..... ₄

1 year to less than 3 years ago.... ₂ Never had one..... ₅

3 years to less than 5 years ago... ₃ DK ₈

Mammogram

15-20 {mamkno} Have you ever heard of a **mammogram**? Y₁ N₂ DK₈ Missing₉

A mammogram is an x-ray taken of the breasts by a machine that presses against the breast while the picture is taken.

15-21 {mamhad} Have you ever had a mammogram? Y₁ N₂ **go to 16-1** DK₈ Missing₉

15-22 {mamwhen} When did you have your last mammogram?

Less than 1 year ago..... ₁ 5 or more years ago..... ₄

1 year to less than 3 years ago.... ₂ don't know..... ₈

3 years to less than 5 years ago... ₃

16. Visual Function and change in visual function

Use of Glasses

- 16-1 {glass} Do you wear **glasses** of any kind?
Y 1 N 2 **go to 16-7** DK 8 Missing 9
- 16-2 {typgls} **If yes**, are they:
single vision distance glasses only.....1 don't know8
single vision reading glasses only.....2 missing.....9
separate reading and distance glasses.....3
bifocals.....4
multifocals.....5
- 16-3 {agegls} How old were you when you first needed to wear glasses to see clearly in the **distance**?
.....years old don't wear distance glasses 1 DK 8 Missing 9
- 16-4 {presby} How old were you when you first needed **reading glasses, bifocals or multifocals**?
.....years old don't wear reading glasses 1 DK 8 Missing 9
- 16-5 {timegls} How long have you had your current glasses?
Glasses are.....years old DK 8 Missing 9
- 16-6 {timglst} When did you last have the strength of your glasses checked?years ago
DK 8 Missing 9
- 16-7 {rdnews} Can you read the ordinary print in the newspaper reasonably well, with or without glasses?
Y1 **go to 16-9** N2 DK8 Missing 9
- 16-8 {lastrd} **If no**, when were you last able to do this?years ago DK 8 Missing 9
- 16-9 {magnif} Do you use a magnifier to read? Y 1 N 2 DK 8 Missing 9

Eye Symptoms

- 17-1 {Vworse} Are you aware of a **deterioration of vision** in one or both eyes?
yes, R eye.....1 **go to 17-2** no.....4 **go to 17-4**
yes, L eye.....2 **go to 17-3** don't know ... 8
yes, both eyes.....3 missing.....9
- 17-2 {Rworse} When did your right eye worsen?mths ago
- 17-3 {Lworse} When did your left eye worsen?mths ago

Are you aware of:

	Right eye	Left eye
17-4 any distortion of straight lines?	{Rdistor} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths	{Ldistor} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths
17-5 a dark patch?	{Rpatch} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths	{Lpatch} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths
17-6 Flashing lights?	{Rlight} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths	{Llight} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths
17-7 Floaters?	{Rfloat} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths	{Lfloat} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths
17-8 any other changes?	{Rchang} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths {Rdetail}Specify.....	{Lchang} yes <input type="checkbox"/> 1 no <input type="checkbox"/> 2 If yes, for how long? .....mths {Ldetail}Specify.....

17-9 {seenite} Do you think you have more difficulty **seeing in the dark** than others of your age?
Y 1 N 2 DK 8 Missing 9

17-10 {glare} Do you think you are more sensitive than others of your age to **sunlight or glare**?
Y 1 N 2 DK 8 Missing 9

In the last 12 months have you noticed any of the following **eye problems**?

	Yes	No	DK	Missing	Which eye?	Duration of symptoms?	Severity of symptoms
17-11 {discom} Discomfort	1	2	8	9	<input type="checkbox"/> Right <input type="checkbox"/> Left	.....months <input type="checkbox"/> still ongoing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
17-12 {gritty} Grittiness	1	2	8	9	<input type="checkbox"/> Right <input type="checkbox"/> Left	.....months <input type="checkbox"/> still ongoing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
17-13 {itchy} Itchiness	1	2	8	9	<input type="checkbox"/> Right <input type="checkbox"/> Left	.....months <input type="checkbox"/> still ongoing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
17-14 {tears} Watering	1	2	8	9	<input type="checkbox"/> Right <input type="checkbox"/> Left	.....months <input type="checkbox"/> still ongoing	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

17-15 {dryeye} For the past 3 months or longer, have you had dry eyes? (foreign body sensation with itching and burning, sandy feeling, not related to allergy)
Y 1 N 2 DK 8 Missing 9

If yes, which eye was affected? Right 1 Left 2 Both 3 DK 8 Missing 9

17-16 {colour} Are you colour blind? Y 1 N 2 DK 8 Missing 9

17-17 {coltype} **If yes, do you know what type of colour blindness?**
 | code.....

17-18 {coltest} Has this been confirmed by tests? Y 1 N 2 DK 8 Missing 9

17-19 {domeye} To which eye would you normally hold a telescope to?
R 1 L 2 Either 3 DK 8 Missing 9

18. Family History

Some eye diseases run in families, so I would like to ask about **eye problems** in your relatives, that is: your **parents, children, or brothers and sisters**.

Have any been diagnosed with?:	yes	no	don't know	missing
18-1 {famgl} glaucoma (high pressure in the eyes)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
18-2 {famcat} cataract	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
18-3 {famamd} macular degeneration (ageing at the back of the eye)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
18-4 {famdb} diabetes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
18-5 {fambl} blindness from any other cause	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
18-6 {famoht} other eye problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9

If **yes** to 18-1 to 18-6 of the above please complete the following table:

N.B. Include age of cataract surgery

Relative	Code	Diagnosis	Code
<i>eg brother</i>		<i>glaucoma</i>	
		<i>diabetes</i>	
	18-7a {fam1}		18-7 {famhis1}
			18-8 {famhis2}
	18-9a {fam}		18-9 {famhis3}
			18-10 {famhis4}
	18-11a {fam5}		18-11 {famhis5}
			18-12 {famhis6}
	18-13a {fam7}		18-13 {famhis7}
			18-14 {famhis8}

18-15 {fathal} Is your **father**? alive 1 dead 2 (age at death years old)
DK 8 Missing 9

18-16 {mothal} Is your **mother**? alive 1 dead 2 (age at death years old)
DK 8 Missing 9

18-17 {brono} How many full brothers have you had, that is alive or dead?
DK 8 Missing 9

18-18 {broal} How many are still alive?.....
DK 8 Missing 9

18-19 {sisno} How many full sisters have you had, that is alive or dead?
DK 8 Missing 9

18-20 {sisal} How many are still alive?.....
DK 8 Missing 9

19. Lifestyle Assessment

Smoking

19-1 {smokin} Have you ever smoked cigarettes, cigars or a pipe regularly? (regularly being at least weekly)
 Y 1 N 2 **go to 19-6** DK 8 Missing 9

If yes, which of the following have you ever regularly smoked:

	yes	no	age smoked from	average amount per week	
			<i>Eg age 15 years to 45 years</i>		
19-2a {cighx} Cigarettes? (Ready-made)	1	2	.....age (yrs) -.....age (yrs)	..... packs (20 per pack)	| code.....
19-2b {cighx} Cigarettes? (Roll-your-own)	1	2	.....age (yrs) -.....age (yrs)	..... packets of tobacco	| code.....
19-2c {piphx} Pipe?	1	2	.....age (yrs) -.....age (yrs)	..... packs of pipe tobacco	| code.....
19-2d {cigar} Cigars?	1	2	.....age (yrs) -.....age (yrs)	..... cigars (number)	| code.....

19-3 {stopsmk} Have you **given up** smoking? Y 1 N 2 **go to 19-5** DK 8 Missing 9

19-4 {pastcig} How much did you usually smoke per week just before you stopped? **go to 19-6**
 packs of manufactured cigs (20 per pack)
 packets of hand-rolled cigs
 cigars
 packets of pipe tobacco

19-5 {curr cig} How much do you smoke per week **currently**?
 packs of manufactured cigs (20 per pack)
 packets of hand-rolled cigs
 cigars
 packets of pipe tobacco

19-6 {spsmk} Is your **husband/wife/partner**:
 a current smoker?..... 1 **go to 19-7** spouse deceased..... 4 **go to 19-12**
 an ex-smoker?..... 2 **go to 19-9** divorced..... 5 **go to 19-12**
 a never smoker?..... 3 **go to 19-18** no spouse/partner 6 **go to 19-18**
 don't know 8 **go to 19-18** missing..... 9

If spouse a current smoker,

19-7 {spcig} On average how much do you think your husband/wife/partner smokes per week?
 packs of manufactured cigs (20 per pack)
 packets of hand-rolled cigs
 cigars
 packets of pipe tobacco

19-8 {spsmyr} What year did he/she **start** smoking?
 (if already smoking when married give year of marriage)(year) **go to 19-18**

If spouse an ex-smoker,

19-9 {spcig} On average how much do you think your husband/wife/partner smoked **per week** just before he/she stopped?
 packs of manufactured cigs (20 per pack)
 packets of hand-rolled cigs
 cigars
 packets of pipe tobacco

19-10 {spsmyr} What year did he/she **start** smoking?
(if already smoking when married give year of marriage)

19-11 {spst} When did he/she **stop** smoking? Gave up in(year) **go to 19-18**

If spouse deceased or divorced,

19-12 {decsm1} At the time of death/divorce, was your husband/wife/partner
a smoker?.....1 **go to 19-13**
an ex-smoker?.....2 **go to 19-15** don't know8 **go to 19-18**
a never smoker?.....3 **go to 19-18** missing.....9 **go to 19-18**

If deceased/divorced spouse a smoker,

19-13 {decsm1} At the time of death/divorce, on average how much do you think your
husband/wife/partner smoked **per week**?
..... packs of manufactured cigs (20 per pack)
..... packets of hand-rolled cigs
..... cigars
..... packets of pipe tobacco

19-14 {decsm2} What year did he/she **start** smoking?(year)
(if already smoking when married give year of marriage)

19-14a {dec2} In what year did he/she die? (**or** in what year did you separate?)(year) **go to 19-18**

If deceased/divorced spouse an ex-smoker,

19-15 {decsm3} On average, how much do you think your husband/wife/partner smoked **per week** just
before they stopped?
..... packs of manufactured cigs (20 per pack)
..... packets of hand-rolled cigs
..... cigars
..... packets of pipe tobacco

19-16 {decsm4} What year did he/she **start** smoking?(year)
(if already smoking when married give year of marriage)

19-17 {decsm5} When did he/she **stop** smoking? Gave up in(year)

Alcohol

I would like to ask you some questions to see whether alcohol causes eye problems or whether it has any benefits for the eyes.

19-18 {alc} How often do you have an alcoholic drink?
never..... 1 **go to 19-21** 5-6 days a week 5
<once a week..... 2 every day 6
1-2 days a week..... 3 don't know 8
3-4 days a week..... 4 missing 9

19-19 {alctype} What do you **mostly** drink?
light beer..... 1 fortified wine..... 5
beer..... 2 others..... 6
wine..... 3 don't know 8
spirits..... 4 missing..... 9

19-20 {alcnnum} On days when you have a drink, how many drinks do you usually have?

- | | | | |
|-----------|----------------------------|------------------|----------------------------|
| 1-2..... | <input type="checkbox"/> 1 | 13 or more..... | <input type="checkbox"/> 5 |
| 3-4..... | <input type="checkbox"/> 2 | don't know | <input type="checkbox"/> 8 |
| 5-8..... | <input type="checkbox"/> 3 | missing..... | <input type="checkbox"/> 9 |
| 9-12..... | <input type="checkbox"/> 4 | | |

19-21 {alcpast} Has there ever been a time in your life when you regularly drank four or more alcoholic drinks a day? Y 1 N 2 DK 8 Missing 9

Mobile Telephone Use

I am now going to ask you about your use of mobile phones.

19-22 {mob} Do you currently use a mobile phone? Y 1 N 2 **go to 20-1** DK 8 Missing 9

19-23 {mobyrs} **If yes**, for how many years have you used it?.....yrs DK 8 Missing 9

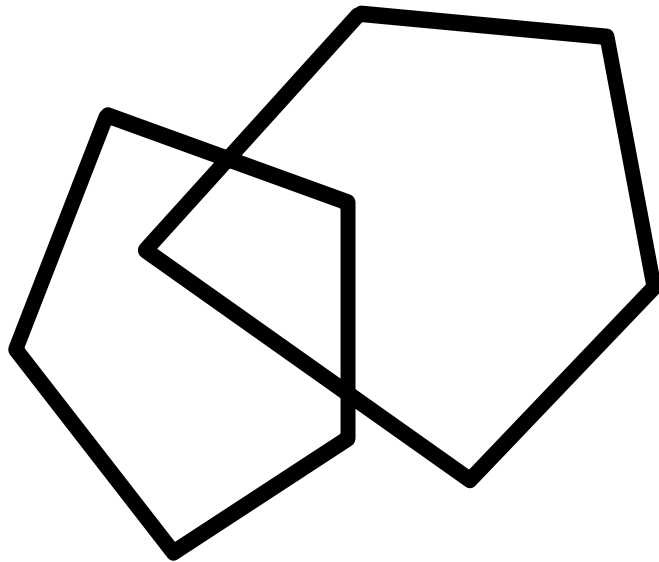
19-24 {earmob} Which ear do you normally hold it to? right 1 left 2 both 3
DK 8 Missing 9

20. Mini-Mental State Exam

The next set of questions are about memory. They may seem a bit childish but this is a standard questionnaire that we are asking everyone. Some of the questions are difficult, so don't be surprised if you have trouble with some of them.

		Points
20-1	{year} What is the year?	...../1
20-2	{season} What is the season?	...../1
20-3	{date} What is the date?	...../1
20-4	{day} What is the day?	...../1
20-5	{month} What is the month?	...../1
20-6	{state} Where are we? State?	...../1
20-7	{country} Country?	...../1
20-8	{own} City/ town?	...../1
20-9	{hospit} Clinic Address?	...../1
20-10	{floor} Floor?	...../1
20-11	{registr} I am going to name three objects. After I have said them, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Give one point for each correct answer. Then repeat the objects up to 6 times until the participant learns all three. APPLE TABLE HORSE /3	
20-12	{attent} Can you subtract 7 from 100, then subtract 7 from the answer you get and keep subtracting 7 until I ask you to stop? (93, 86, 79, 72, 65). Give one point for each correct answer. Stop after five answers If subject refuses or cannot do this, ask them to spell WORLD backwards. _____ /5	
20-13	{recall} What were those three objects I asked you to remember? Give one point for each correct answer /3	
20-14	{langua1} Please name these objects (point to a pencil and a watch) Give one point for each correct answer /2	
20-15	{langua2} Now I would like you to repeat a phrase after me: "No ifs, ands, or buts". /1	
20-16	{langua3} Now I would like you to: Take the paper in your right hand. Fold the paper in half. Put the paper on the floor. /3 Give one point for each correct action	
20-17	{langua4} Please read the words on this bit of paper and do what it says: 'CLOSE YOUR EYES' /1	
20-18	{langua5} Please write a sentence of your own choice. /1 (The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring)	
20-19	{langua6} Please copy the design that you see printed on this paper /1 (Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle)	
20-20	{mmcom1} <i>Was the subject unable to complete 20-17 because of visual impairment?</i> yes..... <input type="checkbox"/> 1 no..... <input type="checkbox"/> 2 unsure..... <input type="checkbox"/> 8 missing..... <input type="checkbox"/> 9	
20-21	{mmcom2} <i>Was the subject unable to complete 20-18 or 20-19 because of arthritis?</i> yes..... <input type="checkbox"/> 1 no..... <input type="checkbox"/> 2 unsure..... <input type="checkbox"/> 8 missing..... <input type="checkbox"/> 9	

CLOSE YOUR EYES



21. Clinical Measurements 1

Chair Stand

C-1 {stand} Do you think it would be safe for you to try to stand up from a chair without using your arms? No 0 Questionable 1 Yes 2

Demonstrate the chair stand for the participant.

“Please fold your arms across your chest and sit so that your feet are on the floor. Try to stand up without using your arms.”

Place the back of the chair against the wall to steady it. Stand next to the participant to provide assistance in case of lost balance. If unable to rise without using arms, say:

“Try to stand up using your arms to push off.”

C-2 {Attempt} Number of attempts to rise: (inc. rocking, weight shifting) _____ attempts

C-3 {standhow} Participant rises:

Without arms <input type="checkbox"/> 0	No-not safe <input type="checkbox"/> 2	Tried/unable <input type="checkbox"/> 8
With arms <input type="checkbox"/> 1	No-wheelchair <input type="checkbox"/> 3	Refused <input type="checkbox"/> 9
	No-chair N/A <input type="checkbox"/> 4	Off-site <input type="checkbox"/> 1
	No time <input type="checkbox"/> 7	

Body Mass Index

C-4 {height} **Height** _____ metres

C-5 {htrel} reliable 1
 unreliable 2 specify..... | code.....
 not done 3 specify..... | code.....

C-6 {wt} **Weight** _____ kilograms

C-7 {wtrel} reliable 1
 unreliable 2 specify..... | code.....
 not done 3 specify..... | code.....

Waist ratio

C-8 {wst} **Waist** _____ cm

C-9 {wstrel} reliable 1
 unreliable 2 specify..... | code.....
 not done 3 specify..... | code.....

22. Disability

General - To be completed by the **examiner**

Does the participant:

	Yes	No	Don't know	Missing
22-1 {D1} have a hearing impairment?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-2 {D2} have walking difficulties	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-3 {D3} use a cane/crutches/walker	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-4 {D4} use a wheel chair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-5 {D5} have SOB/cough continuously	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-6 {D6} have a language problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-7 {D7} have a speech but not a language problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9
22-8 {D8} appear demented	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9

22-9 {D9} **Who mainly answered the questionnaire?**

participant <input type="checkbox"/> 1	sibling <input type="checkbox"/> 4	other <input type="checkbox"/> 7	specify...../code....
spouse <input type="checkbox"/> 2	other relative <input type="checkbox"/> 5	DK <input type="checkbox"/> 8	
son/daughter <input type="checkbox"/> 3	friend <input type="checkbox"/> 6	Missing <input type="checkbox"/> 9	

22-10 {D10} The overall quality of the interview was: reliable1 unreliable2 DK8 missing9

23. Olfaction Test (The San Diego Odour Identification Protocol)

I would now like to test your sense of smell and to detect changes in your ability to recognise everyday odours.

Picture identification

The odours that you will identify by smell are all pictured on this sheet.

I would first like you to name the items pictured.

Starting in the upper left hand corner, would you please name the pictures from left to right in the first row.

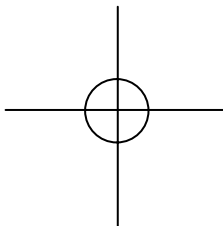
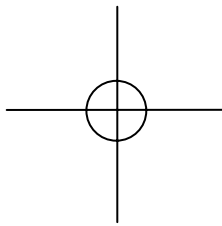
{stffins} Do you have a stuffy nose or a cold at present? Y 1 N 2 DK 8 Missing 9

I would now like to present to you some of the odours pictured here to smell. An odour may be presented more than once. When I present the odours, I will first ask you to close your eyes and then I will place the odour under your nose and ask you to smell. I will then tell you when you can open your eyes and you can either point to the odour on the picture board or say the name of the odour that you smelled.

Odour Identification Score sheet

Picture Recognition				Odour Identification				0=No 1= Yes 9= DK
Recording key	0= incorrect 1= correct 9= don't know	1= trial 1 2= trial 2		Recording key	0= incorrect 1= correct 9= don't know	1= trial 1 2= trial 2		
Odourants	Trial 1	Trial 2	Response	Odourants	Trial 1	Trial 2	Response	Any
a. chewing gum {cg1/ cg2}				1. peanut-butter {pb3/pb4}			/ {pb5/pb6}	{pb7}
b. chicken {ch1/ch2}				2. chocolate {cc3/cc4}			/ {cc5/cc6}	{cc7}
c. vegemite {veg1/ veg2}				3. coffee {c3/c4}			/ {c5/c6}	{c7}
d. toothpaste {t1/ t2}				4. play doh {pd3/pd4}			/ {pd5/pd6}	{pd7}
e. eucalyptus oil {eo1/ eo2}				5. talcum powder {tp3/tp4}			/ {tp5/tp6}	{tp7}
f. pineapple {p1/ p2}				6. chewing gum {cg3/cg4}			/ {cg5/cg6}	{cg7}
g. talcum powder {tp1/ tp2}				7. cinnamon {cn3/cn4}			/ {cn5/cn6}	{cn7}
h. mustard {m1/ m2}				8. mustard {m3/m4}			/ {m5/m6}	{m7}
i. banana {b1/ b2}				Presentation Order Kit Number _____ Room Temp _____ Examiner Initials _____ Olfaction Notes				
j. coffee {c1/ c2}								
k. bread {br1/ br2}								
l. lemon {l1/ l2}								
m. popcorn {pop1/ pop2}								
n. soap (ivory) {s1/ s2}								
o. pizza {pz1/ pz2}								
p. honey {h1/ h2}								
q. watermelon {w1/ w2}								
r. peanut-butter {pb1/ pb2}								
s. strawberry jam {sj1/ sj2}								
t. cinnamon {cn1/ cn2}								

25. Visual fields and grading

	Visual field test	Right	Left
VF-1	24-2 SITA	{rvf} <input type="checkbox"/> completed 1 <input type="checkbox"/> not completed 2 reason..... correction used	{lvf} <input type="checkbox"/> completed 1 <input type="checkbox"/> not completed 2 reason..... correction used
VF-2	Frequency Doubling Test	{rfdt} <input type="checkbox"/> performed 1 <input type="checkbox"/> not performed 2	{lfdt} <input type="checkbox"/> performed 1 <input type="checkbox"/> not performed 2
VF-3	Confrontation	{rconf} <input type="checkbox"/> performed 1 <input type="checkbox"/> not performed 2 	{lconf} <input type="checkbox"/> performed 1 <input type="checkbox"/> not performed 2 

26. A-Scan non contact biometry (IOL master)

		Right	Left
26-1	A-scan (IOL Master)	{riOLm} <input type="checkbox"/> performed 1 <input type="checkbox"/> not performed 2	{liolm} <input type="checkbox"/> performed 1 <input type="checkbox"/> not performed 2

27. Clinical Measurements II

Peak Expiratory Flow

C-10 {pef1} 1st trial _____ Not done 8

C-11 {pef2} 2nd trial _____ Not done 8

C-12 {pef3} 3rd trial _____ Not done 8

C-13 {pefrel} Test is:

Reliable 0

Unreliable 1

While seated 2

Unable 7

No time 8

Refused 9

Glaucoma

- 28-15 {glaucom} Have you ever been told by a doctor that you have **glaucoma**?
Y 1 N 2 **go to 28-23** DK 8 Missing 9
- 28-16 {glauyr} **If yes**, in what year were you first told?(year)
- 28-17 {glauRx} Have you used eyedrops or other medications for glaucoma?
Y 1 N 2 **go to 28-21** DK 8 Missing 9
- 28-18 {glRxyr} **If yes**, in what year did you start using these medications?(year)
- 28-19 {glRxyrs} For how many years? yrs
- 28-20 {glaucdr} Which eye doctor *first* put you on treatment for glaucoma?

- 28-21 {glausur} Have you had an operation or laser treatment for glaucoma?
Y 1 N 2 **go to 28-23** DK 8 Missing 9
- 28-22 {glstryr} **If yes**, in what year?(year)

Diabetes

- 28-23 {dred} Have you **ever** been told by a doctor that you have eye disease or eye damage related to your diabetes (**diabetic retinopathy**)?
Y 1 N 2 **go to 28-29** DK 8 Missing 9
- 28-24 {dredyr} When were you **first** told?.....yrs ago
- 28-25 {drlase} Have you **ever** had laser treatment for your diabetic eye disease?
Y 1 N 2 **go to 28-29** DK 8 Missing 9

If yes,

		Right	Left
28-26	Which eye was treated?	{rdlas} Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9	{ldlas} Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9
28-27	How many years ago?	{rdlasyr}..... years ago	{ldlasyr}..... years ago

- 28-29 {drlasdr} Which eye doctor performed the laser treatment?

Eye trauma

- 28-29 {treye} Have you had any **serious eye injuries** requiring doctor's care?
Y 1 N 2 **go to 28-35** DK 8 Missing 9
- 28-30 {trside} **If yes**, which eye was affected?
right 1 left 2 Both 3 DK 8 Missing 9

	Trauma	Right Eye	Left Eye
28-31	...was this due to being hit by a blunt object? (like a fist, ball, or dashboard of a car)	{rbltr} Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9	{lbltr} Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9
		{rblyr} When?..... years ago	{lblyr} When?..... years ago
		Specify Mechanism	Specify Mechanism

28-32	...was this from a sharp object? (glass, knife or something that penetrated the eye)	{rshtr} Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9	{lshtr} Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9
		{rshyr}When?..... years ago	{lshyr}When?..... years ago
		Specify Mechanism	Specify Mechanism
28-33	...was it due to a chemical burn? (like acid or lye)	{rchtr} Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9	{lchtr} Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9
		{rchtryr}When?..... years ago	{lchtryr}When?..... years ago
		Specify Mechanism	Specify Mechanism
28-34	...did you have to stay in a hospital overnight or longer because of it?	Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9 {rtrhosp}	Yes No DK Missing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 9 {ltrhosp}

Other Eye Conditions

28-35 {retina} Have you ever been told that you have a **problem in the retina** or the '**back of the eye**' eg retinal detachment, vessel blockage or bleeding?
Y 1 N 2 **go to 28-38** DK 8 Missing 9

28-36 {retdet} **If yes, specify** (which eye and condition)
..... | code.....

28-37 {retyr} How many years ago were you first told?years agoage

28-38 Any **other eye problems or surgery** I haven't asked you about?
{other1}..... | code.....
{other2}..... | code.....

22. Clinical Measurements III

Pulse Rate:

C-10 {pr} Pulse rate isbeats per seconds

C-11 {preg} Pulse is regular 1 irregular 2

C-12 {prrel} reliable1
unreliable2 specify.....
not done3 specify.....

Blood pressure:

C-13 {armBP} I am now going to check your blood pressure. Indicate which arm used.
R.. 1 L...2 specify.....
Not done..... 3 specify.....

C-14 {caffBP} Have you had caffeine/ nicotine in last 4 hours? Y 1 N 2 DK 8 Missing 9

C-15 {cuff} Cuff size: small1 adult2 large3

C-16 {systbp} **systolic BP**.....mmHg

C-17 {systbp} **diastolic BP**.....mmHg

C-18 {bprel} reliable1
unreliable2 specify.....
not done3 specify.....

30. Visual Acuity and Subjective Refraction

I am now going to test your vision with your glasses, if you wear them.

Logmar visual acuity score or E – equivalent

measure at 2.4 metres (8 ft) with best distance correction; if unable to see any letters, then try at one metre

E-9 **What distance was chart read?** **R** {Rrddist} 2.4m..... ₁ **L** {Lrddist} 2.4m..... ₁
 1.2m..... ₂ 1.2m..... ₂

E-10 **Current Distance Glasses** {currdrx} **yes**..... ₁ **no**..... ₂

<u>2.4 m</u>	<u>Right eye</u>					<u>no. correct</u>	<u>Left eye</u>					<u>no. correct</u>
6/60	H	V	Z	D	S	.....	H	V	Z	D	S	..... 5
6/48	N	C	V	K	D	.....	N	C	V	K	D	..... 10
6/36	C	Z	S	H	N	.....	C	Z	S	H	N	..... 15
6/30	O	N	V	S	R	.....	O	N	V	S	R	..... 20
6/24	K	D	N	R	O	.....	K	D	N	R	O	..... 25
6/19	Z	K	C	S	V	.....	Z	K	C	S	V	..... 30
6/15	D	V	O	H	C	.....	D	V	O	H	C	..... 35
6/12	O	H	V	C	K	.....	O	H	V	C	K	..... 40
6/9.5	H	Z	C	K	O	.....	H	Z	C	K	O	..... 45
6/7.5	N	C	K	H	D	.....	N	C	K	H	D	..... 50
6/6	Z	H	C	S	R	.....	Z	H	C	S	R	..... 55
6/4.8	S	Z	R	D	N	.....	S	Z	R	D	N	..... 60
6/3.8	H	C	D	R	O	.....	H	C	D	R	O	..... 65
6/3.0	R	D	O	S	N	.....	R	D	O	S	N	..... 70

	Right eye		Left eye
E-11 <small>{RmarVA}</small> Logmar VA	<small>{LmarVA}</small>	Logmar VA
E-12 <small>{RPH}</small> Pinhole	<small>{LPH}</small>	Pinhole

If vision < 6/60

E-13 <small>{RpoorVA}</small>	R	<small>{LpoorVA}</small>	L
	CF		CF.....
	HM.....		HM.....
	PL.....		PL
	NPL.....		NPL.....

Logmar VA modified Sheridan-Gardiner (only if unable to read chart)

E-14 {RSheGar} **R** {LSheGar} **L**

E-15 {amblyo} **If one eye weaker (2 line difference) ask:**

Has your Right/Left eye always been weaker?

right eye -yes..... 1 DK 8
 left eye -yes..... 2 missing..... 9
 no..... 3

E-16 {visdis} **If visual disability, eg field defect or severe visual loss (< 6/60) in both eyes, ask:**

Have you sought help from:

low vision clinic.... 1 Other agency 4
 Royal Blind Society. 2 (specify)..... | code.....
 guide dogs..... 3

E-17 {demenVA} Did mental disability or dementia prevent measurement of VA?

Y 1 N 2 DK 8 Missing 9

VISUAL ACUITY WITH BEST SUBJECTIVE REFRACTION

at	Right eye					no. correct	Left eye					no. correct
2.4 m	H	V	Z	D	S	.....	H	V	Z	D	S	..... 5
6/60	N	C	V	K	D	.....	N	C	V	K	D	..... 10
6/48	C	Z	S	H	N	.....	C	Z	S	H	N	..... 15
6/36	O	N	V	S	R	.....	O	N	V	S	R	..... 20
6/30	K	D	N	R	O	.....	K	D	N	R	O	..... 25
6/24	Z	K	C	S	V	.....	Z	K	C	S	V	..... 30
6/19	D	V	O	H	C	.....	D	V	O	H	C	..... 35
6/15	O	H	V	C	K	.....	O	H	V	C	K	..... 40
6/12	H	Z	C	K	O	.....	H	Z	C	K	O	..... 45
6/9.5	N	C	K	H	D	.....	N	C	K	H	D	..... 50
6/7.5	Z	H	C	S	R	.....	Z	H	C	S	R	..... 55
6/6	S	Z	R	D	N	.....	S	Z	R	D	N	..... 60
6/4.8	H	C	D	R	O	.....	H	C	D	R	O	..... 65
6/3.8	R	D	O	S	N	.....	R	D	O	S	N	..... 70

E-18 {RsubjVA} Logmar VA **Right** {LsubjVA} Logmar VA **Left**

Best subjective refraction

RIGHT

LEFT

E-19 {RsrefDS} sph..... {LsrefDS} sph.....

E-20 {RsrefDC} cyl..... {LsrefDC} cyl.....

E-21 {Rsrefax} axis..... {Lsrefax} axis.....

E-22 {Rsadd} reading add..... {LSadd} reading add.....

Logmar reading chart (add age adjusted plus lens to trial frames)

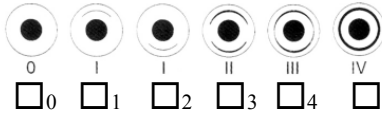
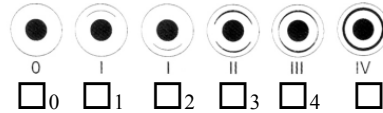
E-23 {newr} **R**..... {newl} **L**..... {newtype} both eyes.....

31. GDX and HRT II

	camera	both	Right only	Left only	None	Reason for inability to take photograph
31-1 {gdx}	GDX	1	2	3	4	
31-2 {rhrt2}	HRT II	1	2	3	4	

32. Slit lamp examination

Anterior Segment Abnormalities

	R eye				L eye					
	none	quest	present	marked	none	quest	present	marked		
L-1 Corneal Arcus	{Rarcus}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	{Larcus}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	{arcgrad}									
L-2 Pingueculum	{Rpingu}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	{Lpingu}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
L-3 Pterygium	{Rptery}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	{Lptery}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	{Rpteryax}	axis.....				{Lpteryax}	axis.....			
L-4 Pseudoexfoliation	{Rexfol}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	{Lexfol}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	{Rdgre}	degree.....				{Ldgre}	degree.....			
L-5 Conjunctivochalasis	{Rcchal}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	{Lcchal}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	{rcgrad}					{lcgrad}				
		Grade 1: no persistent fold..... <input type="checkbox"/> 1				Grade 1: no persistent fold..... <input type="checkbox"/> 1				
		Grade 2: single small fold..... <input type="checkbox"/> 2				Grade 2: single small fold..... <input type="checkbox"/> 2				
		Grade 3: > 2 folds and not higher than the tear meniscus..... <input type="checkbox"/> 3				Grade 3: > 2 folds and not higher than the tear meniscus..... <input type="checkbox"/> 3				
	Grade 4: multiple folds and higher than the tear meniscus..... <input type="checkbox"/> 4				Grade 4: multiple folds and higher than the tear meniscus..... <input type="checkbox"/> 4					
L-6 Corneal opacities	{Ropac}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	{Lopac}	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	{Ropacax}	axis.....				{Lopacax}	axis.....			
L-7 Other	{Rslab1}	.....code.....				{Lslab1}	.....code.....			
	{Rslab2}	.....code.....				{Lslab2}	.....code.....			

L-8 {rshllw} Is the anterior chamber of the right eye judged occludable by slit lamp examination?

Y 1 Stop -do not dilate right eye N 2 DK 8 Missing 9

L-9 {lshllw} Is the anterior chamber of the left eye judged occludable by slit lamp examination?

Y 1 Stop - do not dilate left eye N 2 DK 8 Missing 9

IOP

L-10 {iopt} **Time taken**.....

L-11 {riop1} **Right eye**.....

L-12 {liop} **Left eye**.....

L-13 {iopr} **Was it...**

reliable ₁

unreliable ₂

not done ₃

specify..... | code.....

L-14 {iopl} **Was it...**

reliable ₁

unreliable ₂

not done ₃

specify..... | code.....

Iris Colour

(Use iris photograph reference standards. Do before pupil dilation)

L-16 **Right eye** {irirsr}

< std #1 (blue)..... 1

< std #2 (hazel/green)... 2

< std #3 (tan/brown)..... 3

> std #3 (dark brown)... 4

cannot judge/not done... 5

Left eye{lirirsr}

< std #1 (blue)..... 1

< std #2 (hazel/green)..... 2

< std #3 (tan/brown)..... 3

> std #3 (dark brown)..... 4

cannot judge/not done..... 5

Dilation

Proceed with dilatation using Tropicamide 1% and Phenylephrine 10% in both eyes.

Note reason if dilating drops not instilled.....

STATION 4

30. Hearing Questionnaire

Thank you very much for coming to the Hearing Study today. I am going to ask you some questions about your hearing and other factors that can affect it. I will then conduct a number of hearing tests and will send you a report about these.

1. Hearing Loss

H1-1 [hearloss] Do you feel you have a hearing loss? Y 1 N 2 **go to H1-11** DK 8 Missing 9

H1-2 [whichear] Does it affect your: right ear alone 1 left ear alone 2 both ears 3
 DK 8 Missing 9

H1-3 [heardur] For how long do you feel you've had a problem with your hearing? _____ years

H1-4 [honset] Was the onset of the hearing loss gradual or sudden?
 gradual 1 sudden 2 DK 8 Missing 9

H1-5 [hnotice] Did you or someone else first notice your hearing loss?
 self 1 spouse 2 relative 3
 friend 4 doctor 5 other person 6
 DK 8 Missing 9

H1-6 [hchange] Do you feel that your hearing has changed since we last saw you for the hearing study?
 Y 1 N 2 **go to H2-1** DK 8 Missing 9

H1-7 [hdetails] Other details of hearing loss

H1-8 [sphear] Have you sought help or spoken to any professional about your hearing loss?
 Y 1 N 2 **go to H1-10** DK 8 Missing 9

H1-9 [spheargp] Which of the following have you contacted? multiple responses accepted
 family doctor 1 ENT doctor 2
 audiologist 3 hearing service/ hearing aid provider 4
 self help group (e.g. BHA,ATA,SHHH) 5 DK 8 Missing 9

H1-10 [spsupp] Have you received *treatment or support services for your hearing loss* from any of the following in the past? multiple responses accepted
 family doctor 1 ENT doctor 2
 audiologist 3 hearing service/ hearing aid provider 4
 self help group (e.g. BHA,ATA,SHHH) 5 DK 8 Missing 9

H1-11 [entcurr] Are you currently being treated or followed by a doctor for any hearing or ear condition?
 Yes, current 1 Yes, follow-up 2
 No 3 DK 8 Missing 9

H1-12 [profhear] What are the names of the hearing professionals or services you have visited?

H1-13 [profnam1] Name 1 H1-14 [nam1dur] How long ago? years

H1-15 [profnam2] Name 1 H1-16 [nam2dur] How long ago? years

H1-17 [profnam3] Name 1 H1-18 [nam2dur] How long ago? years

2. Ear infections and other ear conditions

H2-1 [currcold] Have you had a head cold or sinus infection during last seven days?
Y 1 N 2 DK 8 Missing 9

H2-2 [coldnow] Do you have a cold now?
Y 1 N 2 DK 8 Missing 9

H2-3 [earop] Since you last came to the hearing study, have you had any ear operations or treatment given?
Y 1 N 2 DK 8 Missing 9

Please specify _____

3. Family history

Since the last time we examined your eyes or your hearing, have any of your close relatives developed a hearing loss?....including....

your father Y 1 N 2 **go to H3-4** DK 8 Missing 9

H3-1 [fhfather]

H3-2 [fhfaons] Onset? childhood 1 Before age 50 2 After age 50 3 DK 8 Missing 9

H3-3 [fhfadet] Details _____

your mother Y 1 N 2 **go to H3-7** DK 8 Missing 9

H3-4 [fhmother]

H3-5 [fhmoons] Onset? childhood 1 Before age 50 2 After age 50 3 DK 8 Missing 9

H3-6 [fhmodet] Details _____

any brothers Y 1 N 2 **go to H3-10** DK 8 Missing 9

H3-7 [fhbrothe]

H3-8 [fhbrons] Onset? childhood 1 Before age 50 2 After age 50 3 DK 8 Missing 9

H3-9 [fhmodet] Details _____

any sisters Y 1 N 2 **go to H3-13** DK 8 Missing 9

H3-10 [fhsister]

H3-11 [fhsions] Onset? childhood 1 Before age 50 2 After age 50 3 DK 8 Missing 9

H3-12 [fhmodet] Details _____

any children Y 1 N 2 **go to H4-1** DK 8 Missing 9

H3-13 [fhchild]

H3-14 [fhchons] Onset? childhood 1 Before age 50 2 After age 50 3 DK 8 Missing 9

H3-15 [fhchdet] Details _____

4. Head injuries

H4-1 [headinj] Since your last assessment in this study, have you had any serious head injuries, whiplash or been knocked unconscious? Y 1 N 2 DK 8 Missing 9

H4-2 [injdet] Details (Including duration of LOC) _____

H4-3 [concuss] Since your previous assessment, has a doctor ever told you that you had concussion?
Y 1 N 2 DK 8 Missing 9

5. Hearing Aids and Devices

- H5-1 [haworn] Do you or have you ever worn a hearing aid of any type?
 Y 1 **go to H5-5** N 2 DK 8 Missing 9
- H5-2 [harec] Has a hearing aid been recommended to you in the past?
 Y 1 N 2 **go to H5-24** DK 8 Missing 9
- H5-3 [hadidnot] If you did not obtain a hearing aid, Why not? **go to H5 – 24** multiple responses accepted
 too expensive1 put off by others' experience ...5
 concerned with appearance2 other reason6 (complete below)
 considered you didn't need one ..3 not sure7
 too difficult (technical) to use ...4 missing9
- H5-4[hadidnr] Details _____
- H5-5 [hadur] How long have you been using your hearing aid?
 less than 1 year 1 1-5 years 2 6-10 years 3
 more than 10 years 4 DK 8 Missing 9
- H5-6[hanow] Do you have your hearing aids now? Y 1 N 2 **go to H5-15** DK 8 Missing 9
- H5-7 [hear] Do you have one for each ear? Y 1 N 2 DK 8 Missing 9
- H5-8 [hastyle] What style of hearing aid do you have now?
 in the ear 1 in the canal 2 behind the ear 3
 in the glasses 4 body aid 8 DK 8 Missing 9
- H5-9 [habrand] Details of hearing aid type/model _____
- H5-10 [hacoil] Does your hearing aid have a telecoil switch Y 1 N 2 DK 8 Missing 9
- H5-11 [hawear] Do you usually wear both, one or neither of your hearing aids?
 both 1 one 2 neither 2 DK 8 Missing 9
- H5-12 [hause] On average, how many hours per week do you wear at least one?
 never 1 <1hr/week 2 < 1 hour/day 3
 1-4 hrs/day 4 4-8 hrs/day 5 more than 8 hrs/day 6
 DK 8 Missing 9
- H5-13 [haprob] If you have hearing aids, but don't wear them, why not? multiple responses accepted
 doesn't help me to hear1 not working6
 too uncomfortable.....2 don't like the appearance ...7
 hearing aid whistles.....3 other reason11 (complete below)
 unable to put it on4 not sure8
 batteries are too expensive ..5 missing9
- H5-14 [hadidnw] Details _____
- H5-15[haclinic] How satisfied, on a scale of 1 to 10, were you with the clinical service you received at the time of fitting your hearing aid? (that is, professional, helpful, friendly) where 1 is 'not at all satisfied' and 10 is 'very satisfied'.

 Scale 1---2---3---4---5---6---7---8---9---10 number _____

- H5-16 [harepair] Has your hearing aid needed any repairs?
 Y ¹ N ² **go to H5-18** DK ⁸ Missing ⁹
- H5-17 [haclinic] How satisfied, on a scale of 1 to 10, were you with any repair services to your hearing aid? (that is, professional, helpful, friendly) where 1 is 'not at all satisfied' and 10 is 'very satisfied'.
 Scale 1---2---3---4---5---6---7---8---9---10 number _____
- H5-18 [haprovid] Who provided your most recent hearing aid?
 hospital ¹ government (private) ² government (AHS/NAL) ³
 other ⁴ private (own funds) ⁵ DK ⁸ Missing ⁹
- H5-19 [hafit] Who fitted you with your hearing aid?
 ENT doctor ¹ audiologist ² audiometrist/ hearing aid provider ³
 other ⁴ DK ⁸ Missing ⁹

Current Hearing Aids Check

If patient has hearing aids fitted currently, check

Right Aid working:	Yes	No	Left Aid working:	Yes	No
H5-20[rtaidwk]	1	2	H5-21[ltaidwk]	1	2
H5-22[rtbattwk] * If no, flat battery?	1	2	H5-23[ltbattwk] *If no, flat battery?	1	2

Notes/other faults in hearing aids

- H5-24 [ampothor] Have you used any other amplifying devices in the past year? Y ¹ N ² **go to H6-1**
- H5-25 [persamp] **personal amplifier?** Y ¹ N ² **go to H5-27** DK ⁸ Missing ⁹
- H5-26 [ampfreq] How often? once/mth ¹ once/wk ² 5+ days/wk ³ DK ⁸ Missing ⁹
- H5-27 [tvdevice] **TV device?** Y ¹ N ² **go to H5-29** DK ⁸ Missing ⁹
- H5-28 [tvfreq] How often? once/mth ¹ once/wk ² 5+ days/wk ³ DK ⁸ Missing ⁹
- H5-29 [persloop] **personal loop system?** Y ¹ N ² **go to H5-31** DK ⁸ Missing ⁹
- H5-30 [loopfreq] How often? once/mth ¹ once/wk ² 5+ days/wk ³ DK ⁸ Missing ⁹
- H5-31 [telmodif] Have you had your telephone modified for sound? (eg. bell changed, volume switch for incoming call) Y ¹ N ² DK ⁸ Missing ⁹
- H5-32 [haother] **Other comments regarding hearing aids?**
-
-

31. Hearing Examination

6. Otoscopy

Condition	right	left
Normal Study	H6-1[oton1] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9 H6-3[otovw1] Adequate view no wax <input type="checkbox"/> 1 Inadequate view due to wax <input type="checkbox"/> 2 View obscured by wax <input type="checkbox"/> 3	H6-2[oton2] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9 H6-4[otovw2] Adequate view no wax <input type="checkbox"/> 1 Inadequate view due to wax <input type="checkbox"/> 2 View obscured by wax <input type="checkbox"/> 3
TM perforation	H6-5 [tmper1] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9	H6-6 [tmper2] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9
Grommet	H6-7[gromm1] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9	H6-8[gromm2] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9
Exostosis	H6-9[exos1] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9	H6-10[exos2] Yes No DK Missing <input type="checkbox"/> 1... <input type="checkbox"/> 2... <input type="checkbox"/> 8... <input type="checkbox"/> 9
Comments		

7. Audiogram: (If NR at max. output: 888; if DNT: 999)

	RAC	LAC	UBC	RBC	LBC
250Hz	H7-1[rac1]	H7-2[lac1]			
500Hz	H7-3[rac2]	H7-4[lac2]	H7-5[ubc2]	H7-6[rbc2]	H7-7[lbc2]
1000Hz	H7-8[rac3]	H7-9[lac3]	H7-10[ubc3]	H7-11[rbc3]	H7-12[lbc3]
2000Hz	H7-13[rac4]	H7-14[lac4]	H7-15[ubc4]	H7-16[rbc4]	H7-17[lbc4]
3000Hz	H7-18[rac5]	H7-19[lac5]			
4000Hz	H7-20[rac6]	H7-21[lac6]	H7-22[ubc6]	H7-23[rbc6]	H7-24[lbc6]
6000Hz	H7-25[rac7]	H7-26[lac7]			
8000Hz	H7-27[rac8]	H8-28[lac8]			

Audiogram comments

8. Acoustic Impedance:

A. Tymps NR/absent: 888, DNT – 999; Unable to seal – 777; Artefact/negative – 222

	Right	Left
ME pressure	H8-1[rmpress]	H8-2 [lmpress]
TM Compl.	H8-3 [rcompl]	H8-4 [lcompl].....
Cavity Volume	H8-5 [revol]	H8-6 [lcvol]

B. ARTs

Probe Right		
	Contra	Ipsi
500Hz	H8-7[artrc2]	H8-8[artri2]
1000Hz	H8-11[artrc3]	H8-12[artri3]
2000Hz	H9-15[artrc4]	NOT TO TEST

Probe Left		
	Contra	Ipsi
500Hz	H8-9[artlc2]	H8-10[artli2]
1000Hz	H8-13[artlc3]	H8-14[artli3]
2000Hz	H8-16[artlc4]	NOT TO TEST

C. AR Decay Test (at 1Khz – contralateral only)

Right			Left		
H9-17[ardec1]	No decay <input type="checkbox"/> 1	did not test <input type="checkbox"/> 99	H9-18[ardec2]	No decay <input type="checkbox"/> 1	did not test <input type="checkbox"/> 99
	No sig decay <input type="checkbox"/> 2	missing <input type="checkbox"/> 9		No sig decay <input type="checkbox"/> 2	missing <input type="checkbox"/> 9
	Decay <input type="checkbox"/> 3			Decay <input type="checkbox"/> 3	

9. OAE Study

A: TEOAEs: Use NR:888 as necessary

Whole Wave:

Right	Wave Repro	Response (dB)	Stim. Level(pe SPL)	Stim. Stability(%)
	H9-1[toertwr]	H9-2[toertdb]	H9-3[toerts1]	H9-4[toertst]
Left	Wave Repro	Response (dB)	Stim. Level(peSPL)	Stim. Stability(%)
	H9-5[toeltwr]	H9-6[toeltdb]	H9-7[toelts1]	H9-8[toeltst]

Repro and SNR by Frequency:

Right	1000	2000	3000	4000	5000
Repro	H9-9[toertre3]	H9-10[toertre4]	H9-11[toertre5]	H9-12 [toertre6]	H9-13[toertre9]
SNR(dBSPL)	H9-14[toertdb3]	H9-15[toertdb4]	H9-16[toertdb5]	H9-17[toertdb6]	H9-18[toertdb9]
Left	1000	2000	3000	4000	5000
Repro	H9-19[toeltre3]	H9-20[toeltre4]	H9-21[toeltre5]	H9-22[toeltre6]	H9-23[toeltre9]
SNR(dBSPL)	H9-24[toeltdb3]	H9-25[toeltdb4]	H9-26[toeltdb5]	H9-27[toeltdb6]	H9-28[toeltdb9]

STATION 5

Tests done:

	camera	both	Right only	Left only	None	Reason for inability to take photograph
{topcon}	Topcon (Nuclear Lens)	1	2	3	4	
{neitz}	Neitz (Cortical / PSC Lens)	1	2	3	4	
{zeiss}	Zeiss (fundus)	1	2	3	4	

RIGHT EYE

Lens

phakic..... 1

aphakic, AC IOL... 3

enucleated 5

aphakic, no lens 2

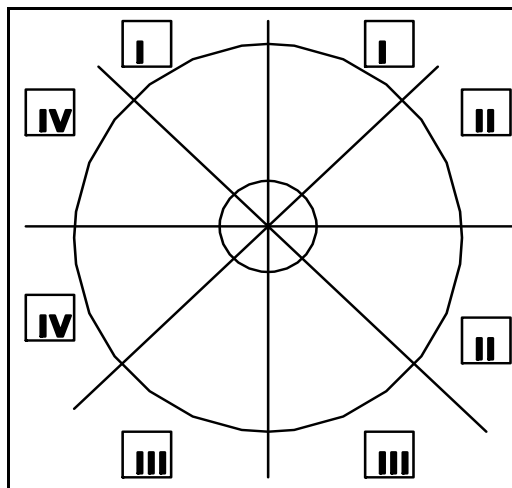
aphakic, PC IOL ... 4

missing 6

Posterior capsular opacity Y 1 N 2 DK 8

YAG Capsulotomy Y 1 N 2 DK 8

	NUCLEAR WISC
≤Std#1	1
≤Std#2	2
≤Std#3	3
≤Std#4	4
>Std#4	5
Mature	6
Can't grade	7



Indicate with a "1" the presence of cortical cataract or PSC in the following lens quadrants

	I	II	III	IV	central circle
PSC					

Please complete the following table by either circling the appropriate number or inserting a percentage

	absent	present	questionable	If VA is 6/12 or worse estimate % visual loss due to factors below	percent of total loss
Hard macular drusen	1	2	3	enucleation	
soft macular drusen	1	2	3	amblyopia	
Visible pigment	1	2	3	cataract	
Geographic atrophy	1	2	3	AMD	
Neovascular AMD	1	2	3	other retinal disease	
Diabetic retinopathy	1	2	3	glaucoma	
Retinal vein occlusion	1	2	3	other optic nerve disease	
Asteroid hyalosis	1	2	3	Corneal disease	
Tilted disc	1	2	3	vitreous media	
Myopic retinopathy	1	2	3	unsure	
Other				other	

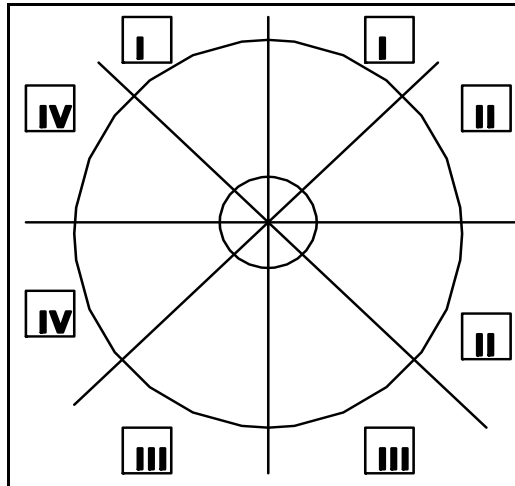
LEFT EYE

Lens

phakic..... 1 aphakic, PC IOL ... 4 enucleated 5
 aphakic, no lens 2 aphakic, AC IOL... 3 missing 6

Posterior capsular opacity Y 1 N 2 DK 8
 YAG Capsulotomy Y 1 N 2 DK 8

	NUCLEAR WISC
≤Std#1	1
≤Std#2	2
≤Std#3	3
≤Std#4	4
>Std#4	5
Mature	6
Can't grade	7



Indicate with a A1" the presence of cortical cataract or PSC in the following lens quadrants

	I	II	III	IV	central circle
PSC					

Please complete the following table by either circling the appropriate number or inserting a percentage

	absent	present	question- able	If VA is 6/12 or worse estimate % visual loss due to factors below	percent of total loss
Hard macular drusen	1	2	3	enucleation	
soft macular drusen	1	2	3	amblyopia	
Visible pigment	1	2	3	cataract	
Geographic atrophy	1	2	3	AMD	
Neovascular AMD	1	2	3	other retinal disease	
Diabetic retinopathy	1	2	3	glaucoma	
Diabetic retinopathy	1	2	3	other optic nerve disease	
Retinal vein occlusion	1	2	3	corneal disease	
Asteroid hyalosis	1	2	3	vitreous media	
Tilted disc	1	2	3	unsure	
Myopic retinopathy	1	2	3	other	
Other					

NOTES: