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Study ID -

Study ID -



The Nakuru Eye Disease Cohort Study

Study Questionnaire 2013

REFERRALS		
DIABETIC	<input type="checkbox"/> Yes - REFER	READING GLASSES DISPENSED? POWER
Distance GLASSES	<input type="checkbox"/> Yes - REFER	
CATARACT	<input type="checkbox"/> Yes - REFER	Any other treatment? E.g. drops
GLAUCOMA	<input type="checkbox"/> Yes - REFER	
DIABETIC RETINOPATHY	<input type="checkbox"/> Yes - REFER	
OTHER	<input type="checkbox"/> Yes - REFER	

Mark Tick Boxes using a black biro with a cross "X", if marked incorrectly, fill in the box and mark the correct box.

e.g. if incorrect fill the box →

Answer Questions in the grey boxes

Phase	Section	Page	Complete?
1	Registration/Demographic Data [A]	3	<input type="checkbox"/>
	Autorefracton [B]	4	<input type="checkbox"/>

Phase	Visual Acuity [A]	Interview [B]	Height/Weight etc. [C]	Slit Lamp – Undilated [D]	Visual Fields [E]
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Page	5-7	8-12	13	14-16	17

All tests above this line must be completed before pupil dilation

Phase	Section	Page	Complete?
3	Dilated Slit Lamp Examination	18-22	<input type="checkbox"/>
	Fundus Camera	23	<input type="checkbox"/>

Study ID -

1. A. Demographic data (Registration Desk)

Cluster Number	3 digit number 001-100				
Individual Number	2 digit number 01-50				
Study ID Number	Cluster Number – Individual Number	<input type="text"/>	<input type="text"/>	--	<input type="text"/>
Date of the examination	Day / Month / Year (dd/mm/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name	text				
Last name	text				
Common name	text				
ID Number	from ID Card if available				
Serial Number	from ID Card if available				
Village name					
Telephone number					
Whose telephone is this?					
Sex	<input type="checkbox"/> Male (1)	<input type="checkbox"/> Female (2)			
Date of birth	Date / Month / Year If year only known enter 99/99/19YY	dd	mm	19	yy
Age	in years (55+)				
Ask "mother tongue"	<input type="checkbox"/> Kikuyu (1)	<input type="checkbox"/> Kalenjin (2)			
	<input type="checkbox"/> Kisii (3)	<input type="checkbox"/> Luo (4)			
	<input type="checkbox"/> Luhyia (5)	<input type="checkbox"/> Masaai (6)			
	<input type="checkbox"/> Kamba (7)	<input type="checkbox"/> Other (8)			
Highest level of Education	<input type="checkbox"/> Primary (1)	<input type="checkbox"/> Secondary (2)	<input type="checkbox"/> College/University (3)	<input type="checkbox"/> None (4)	

I have recorded the data onto the form:

Name

Date

Study ID -

1. B. Refraction (Ophthalmic Nurse)

Refraction?	Right Eye	Left Eye
(Select ONE only)	<input type="checkbox"/> AutoRefraction possible	<input type="checkbox"/> AutoRefraction possible
	<input type="checkbox"/> AutoRefraction not possible	<input type="checkbox"/> AutoRefraction not possible
	<input type="checkbox"/> Manual Refraction	<input type="checkbox"/> Manual Refraction
Refraction Result	Right Eye	Left Eye
Sphere +/- 00.00 (to nearest 0.25)		
Cylinder +/- 00.00 (to nearest 0.25)		
Axis 0-180		
Reliability score (1 to 9)		
Print out Autorefracton and attach to back of booklet		

Study ID -

2.A. Presenting Vision (Ophthalmic Nurse)

Glasses (Select ONE only)	<input type="checkbox"/> Wearing distance glasses (Go to 2.A.a)
	<input type="checkbox"/> Has no distance glasses (Go to 2.A.b)
	<input type="checkbox"/> Forgot distance glasses (Go to 2.A.b)

Wears glasses for reading	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wears aphakic glasses (has had cataract surgery)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2.A.a

Test vision WITH glasses if available. If own glasses not available skip to Question 2.A.b (page 6).

Vision WITH distance or aphakic glasses at 4m	Number of letters seen at 4 meters (0 to 39)	R	L
<i>If Visual Acuity Recorded at 4 meters (greater than 00) in either eye move to next station If misses top E at 4m, move to 1m and retest (Record 00 at 4m)</i>			

Vision WITH distance or aphakic glasses at 1m	Number of letters seen at 1 meter (0 to 39)	R	L
<i>If misses top E at 1m, move to next box (Record 00 at 1m)</i>			

<i>If cannot see at 1m</i> (Select ONE only)	Right Eye	Left Eye
	<input type="checkbox"/> Counting fingers at 1m	<input type="checkbox"/> Counting fingers at 1m
	<input type="checkbox"/> Hand Movements	<input type="checkbox"/> Hand Movements
	<input type="checkbox"/> Perception of light	<input type="checkbox"/> Perception of light
	<input type="checkbox"/> No light perception (in dark)	<input type="checkbox"/> No light perception (in dark)

Study ID -

2.A.b (not needed if vision was tested with own glasses)

Vision WITHOUT glasses at 4m	Number of letters seen at 4 meters (0 to 39)	R	L
<i>If Visual Acuity Recorded at 4 meters (greater than 00) in either eye move to next station If misses top E at 4m, move to 1m and retest (Record 00 at 4m)</i>			

Vision WITHOUT glasses at 1m (if 00 at 4m)	Number of letters seen at 1 meter (0 to 39)	R	L
<i>If misses top E at 1m, move to next box (Record 00 at 1m)</i>			

<i>If cannot see at 1m</i> (Select ONE only)	Right Eye	Left Eye
	<input type="checkbox"/> Counting fingers at 1m	<input type="checkbox"/> Counting fingers at 1m
	<input type="checkbox"/> Hand Movements	<input type="checkbox"/> Hand Movements
	<input type="checkbox"/> Perception of light	<input type="checkbox"/> Perception of light
	<input type="checkbox"/> No light perception (in dark)	<input type="checkbox"/> No light perception (in dark)

Study ID -

2.A.c

Is Best Corrected Visual Acuity (Wearing refraction results) Indicated From Page 4 (Select ONE only)	Vision in Best Eye	
	<input type="checkbox"/> Not indicated (could read 25 or more letters in the best eye) Move patient to next station (miss page 7)	
	<input type="checkbox"/> Indicated (could not read 25 or more letters in the best eye, refraction not available therefore use pinhole.	

NOW TEST BEST CORRECTED/PIN HOLE VISUAL ACUITY IF LESS THAN 25 LETTERS SEEN IN BETTER EYE

How was corrected vision tested (Select ONE only)	<input type="checkbox"/> CORRECTED WITH LENSES
	<input type="checkbox"/> CORRECTED WITH PINHOLE If refraction was not possible
	<input type="checkbox"/> CORRECTED VISION NOT TESTED

Using refraction result from Section 1.B, page 4.

BEST CORRECTED VISUAL ACUITY at 4m	Number of letters seen at 4 meters (0 to 39)	R	L
<i>Move to next station if Best Corrected Visual Acuity Recorded at 4 meters (greater than 00) If misses top E at 4m, move to 1m and retest (Record 00 at 4m)</i>			

BEST CORRECTED VISUAL ACUITY at 1m	Number of letters seen at 1 meter (0 to 39)	R	L
<i>If misses top E at 1m, Record 00 at 1m</i>			

I have recorded the data onto the form:

Name

Date

Study ID -

2.B. General Health (Nurse/Interviewer)

Have you ever been diagnosed with diabetes?	<input type="checkbox"/> Yes (1)		<input type="checkbox"/> No (2)		
If NO, go to next question					
How long ago were you diagnosed with diabetes?	Years (01 – 99) If less than one year, enter "01"				
Are you receiving treatment for diabetes? (select ALL that apply)	<input type="checkbox"/> Yes, insulin (1)	<input type="checkbox"/> Yes, tablets (2)	<input type="checkbox"/> Yes, diet (3)	<input type="checkbox"/> Yes, traditional (4)	<input type="checkbox"/> No (5)

Have you ever been diagnosed with high blood pressure?	<input type="checkbox"/> Yes (1)		<input type="checkbox"/> No (2)		
If NO, go to next question					
How long ago were you diagnosed with high blood pressure?	Years (if less than 1 year mark "0")				
Are you receiving treatment for high blood pressure? (select ALL that apply)	<input type="checkbox"/> Yes, tablets (1)	<input type="checkbox"/> Yes, diet (2)	<input type="checkbox"/> Yes, traditional (3)	<input type="checkbox"/> No (4)	

Have you been diagnosed or are you suffering from any of the following? (tick all that apply)	<input type="checkbox"/> Renal Disease (1)	<input type="checkbox"/> Heart Disease (2)	<input type="checkbox"/> Foot Ulcers (3)	<input type="checkbox"/> None (4)
Did/Do your mother have any of the following?	<input type="checkbox"/> Diabetes (1)	<input type="checkbox"/> High Blood Pressure (2)	<input type="checkbox"/> Blinding eye condition (3)	<input type="checkbox"/> Not sure/None (4)
Did/Do your father have any of the following?	<input type="checkbox"/> Diabetes (1)	<input type="checkbox"/> High Blood Pressure (2)	<input type="checkbox"/> Blinding eye condition (3)	<input type="checkbox"/> Not sure/None (4)
Did/Do your siblings have any of the following?	<input type="checkbox"/> Diabetes (1)	<input type="checkbox"/> High Blood Pressure (2)	<input type="checkbox"/> Blinding eye condition (3)	<input type="checkbox"/> Not sure/None (4)

Study ID -

2.B. continued: Blood Pressure (Nurse)

Take First and Second Blood Pressure Measurements			
First Blood Pressure Reading	Systolic (00 to 250)	Diastolic (00 to 250)	Pulse (00 to 250)
Wait ten minutes between readings. Ensure patient is resting, sitting and no talking whilst BP being taken			
Second Blood Pressure Reading	Systolic (00 to 250)	Diastolic (00 to 250)	Pulse (00 to 250)

Do you drink alcohol? (Answer ONE only)	<input type="checkbox"/> Daily/Most days (1)	<input type="checkbox"/> Weekends only (2)	<input type="checkbox"/> 1-2 times per month (3)	<input type="checkbox"/> Special occasions only (4)	<input type="checkbox"/> Never (5)	<input type="checkbox"/> Former (>6 months) (6)
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Have you ever smoked?	<input type="checkbox"/> Never (1)	<input type="checkbox"/> Former (stopped > 6 months ago) (2)	<input type="checkbox"/> Current (in last 6 months) (3)
If "Never", skip to next question			
		Age at starting	years
		Duration of use	years
		Number of days per week	days (max 07)
		Number smoked per day	

Have you ever snuffed tobacco?	<input type="checkbox"/> Never (1)	<input type="checkbox"/> Former (stopped > 6 months ago) (2)	<input type="checkbox"/> Current (in last 6 months) (3)
If "Never", skip to next question			
		Age at starting	years
		Duration of use	years
		How many days used per week	days (max 07)
		How many times used per day	

Study ID -

2.B. continued

Have you ever chewed tobacco?	<input type="checkbox"/> Never (1)	<input type="checkbox"/> Former (stopped > 6 months ago) (2)	<input type="checkbox"/> Current (in last 6 months) (3)
If "Never", skip to next page			
		Age at starting	years
		Duration of use	years
		Number of days per week	days (max 07)
		Number chewed per day	

Study ID -

2.B. Socioeconomic Status (Nurse/Interviewer)

In the last month have you had a job other than working in the field owned or rented by the household?	<input type="checkbox"/> Yes (1)		<input type="checkbox"/> No (2)	
Major external wall material of your home (Select ONE only)	<input type="checkbox"/> Brick (1)	<input type="checkbox"/> Concrete Block (2)	<input type="checkbox"/> Stone (3)	
	<input type="checkbox"/> Unbaked brick (4)	<input type="checkbox"/> Wood/logs (5)	<input type="checkbox"/> Tin, zinc sheeting (6)	
	<input type="checkbox"/> Flattened tin cans (7)	<input type="checkbox"/> Mud (8)	<input type="checkbox"/> Stone and Mud (9)	
	<input type="checkbox"/> Canvas/Felt (10)	<input type="checkbox"/> Other (11)		
Primary Roof Material of your home (Select ONE only)	<input type="checkbox"/> Concrete (1)	<input type="checkbox"/> Shingles (2)	<input type="checkbox"/> Asbestos Sheets (3)	
	<input type="checkbox"/> Metal Sheets (4)	<input type="checkbox"/> Tile (5)	<input type="checkbox"/> Wood (6)	
	<input type="checkbox"/> Unbaked bricks (7)	<input type="checkbox"/> Thatch (8)	<input type="checkbox"/> Other (9)	
Primary Floor Material of your home (Select ONE only)	<input type="checkbox"/> Parquet (1)	<input type="checkbox"/> Painted wood (2)	<input type="checkbox"/> Tile (3)	
	<input type="checkbox"/> Linoleum (4)	<input type="checkbox"/> Concrete (5)	<input type="checkbox"/> Clay/earthen floor (6)	
	<input type="checkbox"/> Other (7)			
Where is the toilet? (Select ONE only) If more than one toilet mark best one	<input type="checkbox"/> Inside dwelling (1)		<input type="checkbox"/> Outside dwelling – in compound (2)	
	<input type="checkbox"/> Outside dwelling – outside compound (3)		<input type="checkbox"/> Not Applicable/no access to a toilet (uses bush etc) (8)	
Type of toilet? (Select ONE only) If more than one toilet mark best one	<input type="checkbox"/> Flush Toilet (1)	<input type="checkbox"/> Traditional latrine (2)	<input type="checkbox"/> Improved pit latrine with ventilation (VIP)(3)	
	<input type="checkbox"/> Bowl/ Bucket (4)	<input type="checkbox"/> Other (5)	<input type="checkbox"/> No toilet (6)	

Study ID -

Household assets (Select ALL that apply)	<input type="checkbox"/> Radio/Hifi	<input type="checkbox"/> Sewing machine
	<input type="checkbox"/> TV/VCR/DVD	<input type="checkbox"/> Table
	<input type="checkbox"/> Fridge/Freezer	<input type="checkbox"/> Bicycle
	<input type="checkbox"/> Telephone/cell phone	<input type="checkbox"/> Washing machine
	<input type="checkbox"/> Cupboard	<input type="checkbox"/> Motor vehicle/car
	<input type="checkbox"/> Sofaset/armchair	<input type="checkbox"/> Motorbike
How many of the following animals do you possess? <i>Enter "0" if none</i>	Cows?	
	Sheep?	
	Pigs?	
	Chicken/ducks?	

Blood Pressure

Third Blood Pressure Reading	Systolic (00 to 250)	Diastolic (00 to 250)	Pulse (00 to 250)

Treatment history and barriers to uptake (Nurse/Interviewer)









Previous Eye Surgery (Select ALL that apply)	Right Eye	Left Eye
	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Cataract Surgery
	<input type="checkbox"/> Eye lid surgery (Trachoma)	<input type="checkbox"/> Eye lid surgery (Trachoma)
	<input type="checkbox"/> Glaucoma Surgery	<input type="checkbox"/> Glaucoma Surgery
	<input type="checkbox"/> Other	<input type="checkbox"/> Other
	<input type="checkbox"/> No Surgery	<input type="checkbox"/> No Surgery
Current regular medicine for the eyes (Select ALL that apply)	Right or Left Eyes	
	<input type="checkbox"/> Antibiotics	
	<input type="checkbox"/> Steroids	
	<input type="checkbox"/> Anti-Glaucoma	
	<input type="checkbox"/> Lubricant	
	<input type="checkbox"/> Other	
<input type="checkbox"/> No medicines		

Study ID -

Study ID -

2.C. Anthropometry (Nurse)

Patient Age from page 3:	
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Height in cm (no dp)		888: unable, 999: refused	
Weight in kg (1 dp)		888: unable, 999: refused	
Body Fat %		888: unable, 999: refused	
Muscle Mass		888: unable, 999: refused	
Bone MASS		888: unable, 999: refused	
Metabolic Age		888: unable, 999: refused	
Total Body Water %		888: unable, 999: refused	
Visceral Fat Level		01-59 888: unable, 999: refused	
Waist circumference in cm (no dp)		888: unable, 999: refused	
Hip circumference in cm (no dp)		888: unable, 999: refused	

Random blood sugar mmol/L	0.0 to 35.0	
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If ≥ 11.1 mmol/l	HbA1c (%)	Enter number on screen (<4 or >13 may be shown)	
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I have recorded the data onto the form:

Name

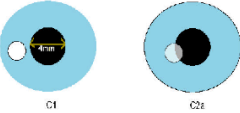
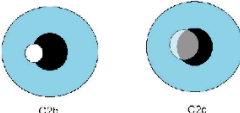




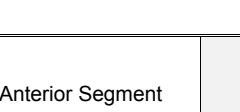
Date

2.D. Anterior Segment Examination (Ophthalmologist)

Relative Afferent Pupil Defect	Right Eye		Left Eye	
	<input type="checkbox"/> Definite	<input type="checkbox"/> Subtle	<input type="checkbox"/> Definite	<input type="checkbox"/> Subtle
	<input type="checkbox"/> No	<input type="checkbox"/> Not able	<input type="checkbox"/> No	<input type="checkbox"/> Not able

Pterygium present and extent mm in to cornea from limbus (0-12)	Right Eye		Left Eye	
	<input type="checkbox"/> No Pterygium		<input type="checkbox"/> No Pterygium	
	<input type="checkbox"/> Pterygium – Cornea NOT involved		<input type="checkbox"/> Pterygium – Cornea NOT involved	
	<input type="checkbox"/> Pterygium – Cornea Involved		<input type="checkbox"/> Pterygium – Cornea Involved	
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	

2.D. continued

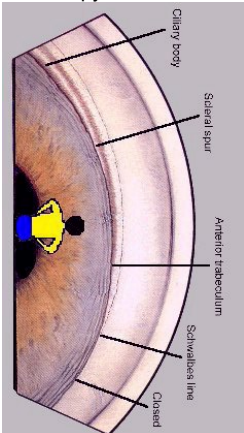
Corneal scarring grade	Right Eye	Left Eye
	<input type="checkbox"/> NO Opacity	<input type="checkbox"/> NO Opacity
	<input type="checkbox"/> Opacity not entering central 4mm (C1)	<input type="checkbox"/> Opacity not entering central 4mm (C1)
	<input type="checkbox"/> Opacity within central 4mm but not entering within the central 1mm of the cornea. The pupil margin is visible through the opacity (C2a)	<input type="checkbox"/> Opacity within central 4mm but not entering within the central 1mm of the cornea. The pupil margin is visible through the opacity (C2a)
	<input type="checkbox"/> Opacity within central 4mm but not entering within the central 1mm of the cornea. The pupil margin is not visible through the opacity (C2b)	<input type="checkbox"/> Opacity within central 4mm but not entering within the central 1mm of the cornea. The pupil margin is not visible through the opacity (C2b)
	<input type="checkbox"/> Opacity within central 4mm and entering the central 1mm of the cornea. The pupil margin is visible through the opacity (C2c)	<input type="checkbox"/> Opacity within central 4mm and entering the central 1mm of the cornea. The pupil margin is visible through the opacity (C2c)
	<input type="checkbox"/> Opacity within central 4mm and entering within the central 1mm of the cornea. The pupil margin is not visible through the opacity (C2d)	<input type="checkbox"/> Opacity within central 4mm and entering within the central 1mm of the cornea. The pupil margin is not visible through the opacity (C2d)
	<input type="checkbox"/> Opacity large enough and dense enough to make whole pupil margin invisible (C3)	<input type="checkbox"/> Opacity large enough and dense enough to make whole pupil margin invisible (C3)
	<input type="checkbox"/> Phthisis (C4)	<input type="checkbox"/> Phthisis (C4)

Anterior Segment	Right Eye	Left Eye
Mark ALL that apply	<input type="checkbox"/> Pseudoexfoliation	<input type="checkbox"/> Pseudoexfoliation
	<input type="checkbox"/> Iris Trans illumination	<input type="checkbox"/> Iris Trans illumination
	<input type="checkbox"/> Krukenberg's Spindle	<input type="checkbox"/> Krukenberg's Spindle
	<input type="checkbox"/> Evidence of previous inflammation	<input type="checkbox"/> Evidence of previous inflammation
	<input type="checkbox"/> None of the above	<input type="checkbox"/> None of the above

2.D. continued

Van Herick's	Right Eye	Left Eye
	<input type="checkbox"/> ACD = 0 or negligible (0)	<input type="checkbox"/> ACD = 0 or negligible (0)
	<input type="checkbox"/> ACD ≤1/4 cornea (1)	<input type="checkbox"/> ACD ≤1/4 cornea (1)
	<input type="checkbox"/> ACD = 1/4 cornea (2)	<input type="checkbox"/> ACD = 1/4 cornea (2)
	<input type="checkbox"/> ACD =1/4-1/2 cornea (3)	<input type="checkbox"/> ACD =1/4-1/2 cornea (3)
	<input type="checkbox"/> ACD >=1/2 cornea (4)	<input type="checkbox"/> ACD >=1/2 cornea (4)
	<input type="checkbox"/> not gradable (9)	<input type="checkbox"/> not gradable (9)

Applanation IOP (mmHg)	99 = not possible	R	L
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Gonioscopy	Right Eye	Left Eye
	<input type="checkbox"/> Nil (0)	<input type="checkbox"/> Nil (0)
	<input type="checkbox"/> Schwalbe's line and anterior meshwork (1)	<input type="checkbox"/> Schwalbe's line and anterior meshwork (1)
	<input type="checkbox"/> Posterior pigmented meshwork (2)	<input type="checkbox"/> Posterior pigmented meshwork (2)
	<input type="checkbox"/> Scleral Spur (3)	<input type="checkbox"/> Scleral Spur (3)
	<input type="checkbox"/> Ciliary Band (4)	<input type="checkbox"/> Ciliary Band (4)
	<input type="checkbox"/> Not gradable (5)	<input type="checkbox"/> Not gradable (5)

Safe to dilate? Yes No

Study ID -

Study ID -

2.E. Visual Fields (Visual Field Technician)







VF completed?	Right Eye	Left Eye
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No – uncooperative	<input type="checkbox"/> No – uncooperative
	<input type="checkbox"/> No – poor visual acuity	<input type="checkbox"/> No – poor visual acuity
	<input type="checkbox"/> No – machine failure	<input type="checkbox"/> No – machine failure
Classification (in the field – by ophthalmologist or OCO)	Right Eye	Left Eye
	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
	<input type="checkbox"/> Abnormal – definite Glaucoma	<input type="checkbox"/> Abnormal – definite Glaucoma
	<input type="checkbox"/> Abnormal – suspect glaucoma	<input type="checkbox"/> Abnormal – suspect glaucoma
	<input type="checkbox"/> Abnormal – non-glaucoma	<input type="checkbox"/> Abnormal – non-glaucoma
Print out Visual Fields and attach to back of booklet		

I have recorded the data onto the form and printed the visual fields:

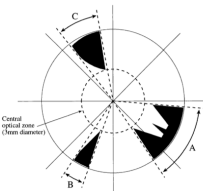
Name

Date

3.A. Dilated Examination (Ophthalmologist)

WHO CATARACT GRADING (See Document for Reference)		
	Right Eye	Left Eye
Cataract		
(Select ONE only)		
3.A.1	[0] <input type="checkbox"/> No cataract	[0] <input type="checkbox"/> No cataract
	[1] <input type="checkbox"/> Gradable cataract	[1] <input type="checkbox"/> Gradable cataract
	[2] <input type="checkbox"/> Mature	[2] <input type="checkbox"/> Mature
	[3] <input type="checkbox"/> Hypermature	[3] <input type="checkbox"/> Hypermature
	[4] <input type="checkbox"/> Corneal Opacity	[4] <input type="checkbox"/> Corneal Opacity
	[5] <input type="checkbox"/> Phytthisis	[5] <input type="checkbox"/> Phytthisis
	[7] <input type="checkbox"/> Aphakia	[7] <input type="checkbox"/> Aphakia
	[8] <input type="checkbox"/> IOL	[8] <input type="checkbox"/> IOL
	[9] <input type="checkbox"/> Can not grade	[9] <input type="checkbox"/> Can not grade
Nuclear	Right Eye	Left Eye
(Select ONE only)		
	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable
	<input type="checkbox"/> Nuclear 0 [0]	<input type="checkbox"/> Nuclear 0 [0]
	<input type="checkbox"/> Nuclear 1 [1]	<input type="checkbox"/> Nuclear 1 [1]
	<input type="checkbox"/> Nuclear 2 [2]	<input type="checkbox"/> Nuclear 2 [2]
	<input type="checkbox"/> Nuclear 3 [3]	<input type="checkbox"/> Nuclear 3 [3]
	<input type="checkbox"/> Aphakia [7]	<input type="checkbox"/> Aphakia [7]
	<input type="checkbox"/> IOL [8]	<input type="checkbox"/> IOL [8]
	<input type="checkbox"/> Cannot grade [9]	<input type="checkbox"/> Cannot grade [9]

3.A. continued

Cortical (Select ONE only)  0: <1/8, 1: 1/8 to <1/4, 2: 1/4 to <1/2, 3: 1/2+	Right Eye			Left Eye		
	<input type="checkbox"/> Not applicable			<input type="checkbox"/> Not applicable		
	<input type="checkbox"/> Cortical 0 [0]			<input type="checkbox"/> Cortical 0		
	<input type="checkbox"/> Cortical 1 [1]			<input type="checkbox"/> Cortical 1		
	<input type="checkbox"/> Cortical 2 [2]			<input type="checkbox"/> Cortical 2		
	<input type="checkbox"/> Cortical 3 [3]			<input type="checkbox"/> Cortical 3		
	<input type="checkbox"/> Aphakia [7]			<input type="checkbox"/> Aphakia		
	<input type="checkbox"/> IOL [8]			<input type="checkbox"/> IOL		
	<input type="checkbox"/> Cannot grade [9]			<input type="checkbox"/> Cannot grade		
Cortical Central? (central 3mm)	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [2]	<input type="checkbox"/> N/A [3]	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [2]	<input type="checkbox"/> N/A [3]

Posterior Subcapsular (PSC) (Select ONE only) 0: <1mm 1: >=1mm, <2mm 2: >=2mm, <3mm 3: >=3mm	Right Eye			Left Eye		
	<input type="checkbox"/> Not applicable			<input type="checkbox"/> Not applicable		
	<input type="checkbox"/> PSC 0 [0]			<input type="checkbox"/> PSC 0 [0]		
	<input type="checkbox"/> PSC 1 [1]			<input type="checkbox"/> PSC 1 [1]		
	<input type="checkbox"/> PSC 2 [2]			<input type="checkbox"/> PSC 2 [2]		
	<input type="checkbox"/> PSC 3 [3]			<input type="checkbox"/> PSC 3 [3]		
	<input type="checkbox"/> Aphakia [7]			<input type="checkbox"/> Aphakia [7]		
	<input type="checkbox"/> IOL [8]			<input type="checkbox"/> IOL [8]		
<input type="checkbox"/> Cannot grade [9]			<input type="checkbox"/> Cannot grade [9]			
Posterior Capsular Opacification (PCO) with IOL	Right Eye			Left Eye		
	<input type="checkbox"/> Yes - within central 3mm [1]			<input type="checkbox"/> Yes - within central 3mm [1]		
	<input type="checkbox"/> No - Clear capsule [2]			<input type="checkbox"/> No - Clear capsule [2]		
	<input type="checkbox"/> Not sure [3]			<input type="checkbox"/> Not sure [3]		
	<input type="checkbox"/> Evidence of capsulotomy [4]			<input type="checkbox"/> Evidence of capsulotomy [4]		
	<input type="checkbox"/> Yes - outside central 3mm [5]			<input type="checkbox"/> Yes - outside central 3mm [5]		
<input type="checkbox"/> N/A [9]			<input type="checkbox"/> N/A [9]			

3.A. continued

POSTERIOR SEGMENT EXAMINATION (1 in 10 participants and those in whom imaging not possible)		
<input type="checkbox"/> I in I0	<input type="checkbox"/> Imaging not possible	<input type="checkbox"/> Not applicable (skip to 3B)

View of PSED at slit lamp	Right Eye		Left Eye	
	<input type="checkbox"/> Clear		<input type="checkbox"/> Clear	
	<input type="checkbox"/> Hazy		<input type="checkbox"/> Hazy	
	<input type="checkbox"/> No view		<input type="checkbox"/> No view	

Vertical Cup to Disc Ratio	0.0 to 1.0	R	<input type="checkbox"/> Can not assess	L	<input type="checkbox"/> Can not assess
VCDR asymmetry (>=0.2)	Both Eyes				
	<input type="checkbox"/> Yes [1]				
	<input type="checkbox"/> No [2]				
Disc Haemorrhage	Right Eye		Left Eye		
	<input type="checkbox"/> Yes [1]		<input type="checkbox"/> Yes [1]		
	<input type="checkbox"/> No [2]		<input type="checkbox"/> No [2]		
Disc Notch	Right Eye		Left Eye		
	<input type="checkbox"/> Yes [1]		<input type="checkbox"/> Yes [1]		
	<input type="checkbox"/> No [2]		<input type="checkbox"/> No [2]		
Disc Atrophy	Right Eye		Left Eye		
	<input type="checkbox"/> Yes [1]		<input type="checkbox"/> Yes [1]		
	<input type="checkbox"/> No [2]		<input type="checkbox"/> No [2]		
<input type="checkbox"/> Can not assess [3]		<input type="checkbox"/> Can not assess [3]			

3.A. continued

Study ID -

Diabetic Retinopathy (Select ONE only)	Right Eye	Left Eye
	<input type="checkbox"/> No diabetic retinopathy	<input type="checkbox"/> No diabetic retinopathy
	<input type="checkbox"/> Non-proliferative	<input type="checkbox"/> Non-proliferative
	<input type="checkbox"/> Proliferative/end stage	<input type="checkbox"/> Proliferative/end stage
	<input type="checkbox"/> Cannot assess	<input type="checkbox"/> Cannot assess
Diabetic Maculopathy (Select ONE only)	<input type="checkbox"/> Diabetic Maculopathy	<input type="checkbox"/> Diabetic Maculopathy
	<input type="checkbox"/> No Diabetic Maculopathy	<input type="checkbox"/> No Diabetic Maculopathy
	<input type="checkbox"/> Cannot assess	<input type="checkbox"/> Cannot assess
Age Related Maculopathy (ARM)	Right Eye	Left Eye
	<input type="checkbox"/> No ARM [1]	<input type="checkbox"/> No ARM [1]
	<input type="checkbox"/> Drusen [2]	<input type="checkbox"/> Drusen [2]
	<input type="checkbox"/> Hypo/hyper pigmentation [3]	<input type="checkbox"/> Hypo/hyper pigmentation [3]
	<input type="checkbox"/> Can not assess [4]	<input type="checkbox"/> Can not assess [4]
Age Related Macular Degeneration (ARMD)	Right Eye	Left Eye
	<input type="checkbox"/> No ARMD	<input type="checkbox"/> No ARMD
	<input type="checkbox"/> Dry or Geographic	<input type="checkbox"/> Dry or Geographic
	<input type="checkbox"/> Wet/Neovascular/Disciform	<input type="checkbox"/> Wet/Neovascular/Disciform
	<input type="checkbox"/> Can not assess	<input type="checkbox"/> Can not assess
Other PSED Pathology	Right Eye	Left Eye
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No
	<input type="checkbox"/> Can not assess	<input type="checkbox"/> Can not assess
If Yes - Specify (free text)	R	L

3.B. Fundus Photography

Study ID -

Participant details entered on home screen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Participant Study ID Number	XXX-XX	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
Camera Failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ANTERIOR SEGMENT & LENS PHOTO <i>SIT PATIENT BACK SLIGHTLY ON CHIN REST (3cm)</i>		
Image clarity	Right Eye	Left Eye
	<input type="checkbox"/> Clear	<input type="checkbox"/> Clear
	<input type="checkbox"/> Hazy	<input type="checkbox"/> Hazy
	<input type="checkbox"/> No view	<input type="checkbox"/> No view
FUNDUS PHOTOGRAPH <i>AUTOMATIC MODE</i> <i>MANUAL IF UNABLE</i>		
Posterior Segment Image clarity	Right Eye	Left Eye
	<input type="checkbox"/> Clear	<input type="checkbox"/> Clear
	<input type="checkbox"/> Hazy	<input type="checkbox"/> Hazy
	<input type="checkbox"/> No view	<input type="checkbox"/> No view

Study ID -

Study ID -

Participant information sheet – to be translated in to Kiswahili and read to participants

THE INCIDENCE AND PROGRESSION OF POSTERIOR SEGMENT EYE DISEASE IN NAKURU COUNTY IN RESIDENTS AGED 55 YEARS AND ABOVE

You are being invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. I will read information to you about this study. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part

What is the purpose of the study?

In the world today there are about 39 million blind people. Approximately half of these people are blind due to cataract, making this the single largest cause of global blindness. In 2007/8 we undertook a survey to investigate how common eye diseases are among older people in Nakuru. This information helps us to plan health services more efficiently. We now want to follow-up the people we examined to see how quickly eye disease progresses and how often new eye disease occurs.

Why have I been chosen?

Every person who was randomly selected for the study 5 years ago (in 2007/2008) is being invited to take part again in the study so we can see what has happened to you over this time,

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What is involved in the study?

We will give you a very complete eye examination to look for any problem at the front and inside the eye using several machines. We will also check the pressure in your eye. Some of the examinations will involve contact with your eye. Some drops will be put in your eye so that you feel no pain. We will also put drops in your eyes to make the pupils as big as possible so we can see inside clearly. This will cause blurring of your near vision for a few hours afterwards and so you will not be able to drive or operate dangerous machinery for the rest of the day. The risks and likelihood of side-effects from this procedure is extremely small. We will also collect information about your history of diabetes, high blood pressure, eye diseases, smoking and alcohol all of which affect your eyes.

Your height, weight and blood pressure will be measured. A finger prick blood sample will be taken to check for diabetes, and a swab from the inside of your cheek will be taken to measure genetic material (DNA). This genetic material carries information for making up our bodies and is different in all people. Having DNA samples helps us to understand whether diseases run in the family. The results are unlikely to have any implications for you personally. We will store the DNA for future laboratory research that may be needed.

All information which is collected about you during the course of the research will be kept strictly confidential and your name will never be released.

Should we find that you could benefit from ant further eye treatment we will arrange an appointment for you to have treatment done at Nakuru eye unit. If you are found to be diabetic or have high blood pressure we will arrange for you be seen at the Nakuru provincial hospital. You will have to pay normal hospital fees for some of the treatment at the hospital. It is up to you to decide whether you would like to take up the offer of treatment or not.

CONSENT FORM

The information sheet concerning this study has been read to me, and I understand what will be expected of me if I take part in this study.

My questions concerning this study have been answered by _____. I understand that participation in this study is voluntary. I also understand that I may withdraw from this study at any time without giving a reason and that this will not affect my normal care.

I agree to take part in this study.

I agree to have a sample of genetic material (DNA) taken: Yes/No

Name of study subject: _____

Signature or thumbprint _____

Witness _____

Date _____

* Witness: By signing in this column I warrant that I have read this form and the information form to the persons against whose names my signature appears. I am sure that each of these persons has understood what is required of him/her and has agreed to take part in the study.