Annexure
OCULAR DISORDERS IN SOUTHERN DISTRICTS OF TAMILNADU AND ANTI-MICROBIAL STUDY ON OCULAR PATHOGENS

QUESTIONNAIRE ON EYE CARE

Name : Date :
Address : Phone :
Date of Birth :
Sex : Male □ Female □
Age in years :
Marital Status :
□ Single □ Married □ Divorced □ Widowed

Name of the Medical centre:

1. Why are you here?
   □ To examine the eye □ To have regular check up
   □ To have treatment □ To admit for eye surgery

2. What is your occupation
   □ Student □ Agricultural Labourer
   □ Professionals □ Skilled workers

3. What type of eye defect do you have
   □ Cataract □ Conjunctivitis
   □ Glaucoma □ Myopia

4. How did you develop the injury?
   □ Chemicals □ Dust □ Heat □ Any other source.

5. What type of diseases that have affected your eyes?
   □ Bacterial □ Viral □ Fungal
6. If there is no disease whether your eyes are affected by any damage?
   - Sharpe metal or Wood
   - Plant material
   - Animal parts
   - Insects

7. Nature of injury
   - Corneal
   - Retinal
   - Lens
   - Surface Injury

8. Which eye is affected?
   - Right eye
   - Left eye
   - Both eyes

9. How long you are suffering from this eye disease?
   - From childhood
   - After Surgery
   - After an accident
   - Recently

10. How much discomfort do you have in your eyes due to eye problem?
    - Burning
    - Itching
    - Aching
    - Pricking

11. Do you currently have any constitutional problem due to eye problem?
    - Fever
    - Weight Loss
    - Head ache
    - Weight Gain

12. Does your eyes become dry due to any of these medication?
    - Pills
    - Diabetics
    - Blood Pressure
    - Hormone therapy

13. Is your eye problem hereditary?
    - Yes
    - No
    - I don’t Know
    - May be

14. Have you worn contact lens?
    - Yes
    - No
    - may be in future
    - No idea

15. If you have worn contact lenses in the past, which of the following did you wear most recently?
    - Rigid gas permeable
    - Disposable (lens replace frequently)
    - Soft daily wear (lenses replaced after one year)
    - Extended wear (lenses worn overnight)

16. Did you stop using contact lens?
    - Yes
    - No
    - not applicable
17. Why did you stop using contact lens?
   - Uncomfortable
   - Eyes felt dry
   - Lenses felt scratchy and irritating
   - Vision was not clear.

18. How long are you using lens?
   - > 10 yrs
   - > 5 yrs
   - > 2 yrs
   - Recently

19. Do you have other health issues?
   - Bp
   - Thyroid
   - Diabetics
   - Hyperlipidemic

20. At present, what is the condition of your eyesight using both eyes with glasses or contact lenses?
   - Excellent
   - Good
   - Fair
   - Poor

21. How is your eye disease currently interfering with your overall quality of life?
   - Does not interfere
   - Slightly interfere
   - Most of the time
   - Completely interfere

22. Whether your eye disease upset your mind?
   - Yes
   - No

23. If yes, how many times in a day do you worry about your eye problem?
   - None of the time
   - Some of the time
   - Most of the time
   - All the time

24. How is your eye disease currently interfering with your ability to carry out daily activities?
   - Does not interfere
   - Slightly interfere
   - Mostly
   - Completely

25. How much difficulty did you have reading newspapers?
   - No difficulty
   - Moderate
   - Extreme
   - Stopped reading

26. Did you have surgery on one or both eyes?
   - One
   - Both
   - None
27. Does your vision allow you to drive?
   - Yes
   - No
   - Occasionally

28. Do you have difficulty in recognizing people due to your vision problem?
   - Yes
   - No
   - Night
   - Light

29. Whether the similar eye problem is in your family?
   - Yes
   - No

30. If yes, who are affected?
   - Parents
   - Grant Parents
   - Siblings
   - Cousins

31. Are you a Vegetarian or Non Vegetarian?
   - Vegetarian
   - Non vegetarian
   - both of them

32. If Vegetarian do you take Vitamin A rich foods regularly?
   - Yes
   - No
   - Occasionally