Take-home Questionnaire Booklet

Study ID number: ____________________

Name: ____________________________

COMPLETION DATE: ☐☐/☐☐/☐☐☐☐

Please return using paid reply envelope provided, within ONE month of your appointment date. If you require assistance to complete this questionnaire, please contact ***0408 910 966***

Principal Investigator

Professor Paul Mitchell
AO, MBBS, MD, PhD, FRANZCO, FRACS, FRCOphth, FAFPHM
Email: paul.mitchell@sydney.edu.au
Phone: +61 428 496 141

Associate Investigators

Professor Bamini Gopinath
BTech(Hons), PhD

A/Prof Gerald Liew
MBBS, MMed, PhD, FRANZCO

A/Prof Gian Luca Di Tanna
MSc, PhD

Professor Lisa Keay
BOptom, MPH, PhD

Tim Fricke
BOptom, MSc, GCOT, GDipIntDev, FAAO

Ms Colina Waddell

1. National Eye Institute: Visual Function Questionnaire

Part 1 - General Vision

1-1. At the present time, would you say your eyesight using both eyes (with glasses if worn) is excellent, good, fair, poor, or very poor or are you completely blind? *(Tick one)*

☐1 Excellent
☐2 Good
☐3 Fair
☐4 Poor
☐5 Very Poor
☐6 Completely blind

1-2. How much of the time do you worry about your eyesight? *(Tick one)*

☐1 None of the time
☐2 A little of the time
☐3 Some of the time
☐4 Most of the time
☐5 All of the time

1-3. How much pain or discomfort have you had in and around your eyes (for example, burning, itching or aching)? Would you say it is: *(Tick one)*

☐1 None of the time
☐2 A little of the time
☐3 Some of the time
☐4 Most of the time
☐5 All of the time

Part 2 - Difficulty with Activities

1-4. How much difficulty do you have, even with glasses, reading common printed forms e.g. applications, newspapers? Would you say you have: *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-5. How much difficulty do you have, even with glasses, doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say: *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-6. Because of your eyesight, even with glasses, how much difficulty do you have finding something on a crowded shelf? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-7. How much difficulty do you have, even with glasses, reading street signs or the names of shops? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-8. Because of your eyesight, even with glasses, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-9. Because of your eyesight, even with glasses, how much difficulty do you have noticing objects off to the side while you are walking along? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-10. Because of your eyesight, even with glasses, how much difficulty do you have seeing how people react to things you say? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-11. Because of your eyesight, even with glasses, how much difficulty do you have picking out and matching your clothes? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-12. Because of your eyesight, even with glasses, how much difficulty do you have visiting people in their homes, at parties, or in restaurants? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-13. Because of your eyesight, even with glasses, how much difficulty do you have going out to see movies, plays, or sports events? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-14. How much difficulty do you have, even with glasses, reading a large-print book or large print-newspaper or numbers on a telephone? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-15. How much difficulty do you have, even with glasses, recognising people when they are close to you? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-16. How much difficulty do you have, even with glasses, writing out cheques or filling out forms? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-17. How much difficulty do you have, even with glasses, watching television? *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-18. Are you <u>currently driving</u>, at least once in a while? *(Tick one)*

☐1 Yes **Go to Q1-22**
☐2 No

1-19. **If no**: Have you never driven a car or have you given up driving? *(Tick one)*

☐1 Never drove **Go to Q1-33**
☐2 Gave up

If you gave up driving:

1-20. How many years ago did you give up driving? ________ years ago

1-21. Did you give up mainly because of your eyesight, mainly for some other reasons, or because of both your eyesight and other reasons? (*Tick one)*

☐1 Mainly eyesight **Go to Q1-33**
☐2 Mainly other reasons **Go to Q1-33**
☐3 Both eyesight and other reasons **Go to Q1-33**

If currently driving:

1-22. Do you intend to give up driving in the next 12 months?

☐1 Yes
☐2 No **Go to Q1-24**

1-23. Why do you intend to give up driving?

☐1 Mainly eyesight
☐2 Mainly other reasons
☐3 Both eyesight and other reasons

1-24. What type of licence do you have?

☐1 Unconditional
☐2 Conditional, please specify what conditions:

____

1-25. How much difficulty do you have driving during the daytime in familiar places? Would you say you have: *(Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty

1-26. How much difficulty do you have driving at night? Would you say you have: (*Tick one)*

☐1 No difficulty at all
☐2 A little difficulty
☐3 Moderate difficulty
☐4 Extreme difficulty
☐5 Stopped doing this because of your eyesight
☐6 Stopped doing this for other reasons or not interested in doing this

1-27. If you have any difficulty driving, have you made any changes? (*Tick one)*

☐1 Driving less, please specify: _______ times/ week
☐2 Driving slower
☐3 Driving shorter distances
☐4 Other, please specify: ________________________________

1-28. Do you think your driving ability now is as good as it used to be?

☐1 Yes
☐2 No

1-29. **If no:** do you think this might be related to your vision?

☐1 Yes
☐2 No

1-30. Have you had any car accidents in the last 12 months?

☐1 Yes
☐2 No **Go to Q1-33**

If yes:

1-31. How many accidents have you had? ___________

1-32. Do you think your vision was a cause of the accident?

☐1 Yes
☐2 No

Part 3 – Vision Problems

The next questions are about things affecting your vision. For each one, please circle the number to indicate whether the statement is true for you all, most, some, a little, or none of the time. *(Tick one on each line)*

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
1-33. Do you accomplish less than you would like because of your vision	☐1	☐2	☐3	☐4	☐5
1-34. Are you limited in how long you can work or do other activities because of your vision?	☐1	☐2	☐3	☐4	☐5
1-35. Does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:	☐1	☐2	☐3	☐4	☐5

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.
(*Tick one on each line)*

	Definitely true	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
1-36. I stay home most of the time because of my eyesight	☐1	☐2	☐3	☐4	☐5
1-37. I feel frustrated a lot of the time because of my eyesight	☐1	☐2	☐3	☐4	☐5
1-38. I have much less control over what I do, because of my eyesight	☐1	☐2	☐3	☐4	☐5
1-39. Because of my eyesight, I have to rely too much on what other people tell me	☐1	☐2	☐3	☐4	☐5
1-40. I need a lot of help from others because of my eyesight	☐1	☐2	☐3	☐4	☐5
1-41. I worry about doing things that will embarrass myself or others, because of my eyesight	☐1	☐2	☐3	☐4	☐5

2. Dry Eye

2-1. Have you ever been told you have dry eyes?

☐1 Yes ☐2 No

2-2. If yes, in which eye?

☐1 Right eye ☐2 Left eye ☐3 Both eyes

Ocular Surface Disease Index-12 (OSDI-12)

	Constantly	Mostly	Often	Sometimes	Never
Have you experienced any of the following *during the last week?*					
2-3. Eyes that are sensitive to light?	4	3	2	1	0
2-4. Eyes that feel gritty?	4	3	2	1	0
2-5. Painful or sore eyes?	4	3	2	1	0
2-6. Blurred vision?	4	3	2	1	0
2-7. Poor vision?	4	3	2	1	0
				a) Subtotal score for answers 2-3 to 2-7	

Have problems with your eyes limited you in performing any of the following *during the last month?*					
2-7. Reading?	4	3	2	1	0
2-8. Driving at night?	4	3	2	1	0
2-9. Working with a computer or bank machine (ATM)?	4	3	2	1	0
2-10. Watching TV?	4	3	2	1	0
b) Subtotal score for answers 2-6 to 2-10					
Have your eyes felt uncomfortable in any of the following situations *during the last week?*					
2-11. Windy conditions?	4	3	2	1	0
2-12. Places or areas with low humidity (very dry)?	4	3	2	1	0
2-13. Areas that are air conditioned?	4	3	2	1	0
c) Subtotal score for answers 2-11 to 2-13					

FOR OFFICE USE ONLY:

Add subtotals a), b), and c): ______

Total number of questions answered (do not include questions answered N/A): ______

3. Ear infections (Otitis Media) and other ear conditions

3-1. Have you had a head cold or sinus infection during the last seven days?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

3-2. Do you have a cold now?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

3-3. Have you ever had an ear infection?

- ☐ Yes
- ☐ No (go to Q3-14)
- ☐ Don't know
- ☐ Missing

3-4. Did you have any ear infections as a child (aged < 18 years)?

- ☐ Yes
- ☐ No (go to Q3-9)
- ☐ Don't know
- ☐ Missing

3-5. How often did you have ear infections as a child (aged < 18 years)?

- ☐ Once
- ☐ At least once a year
- ☐ Two-three times a year
- ☐ Once every few years
- ☐ Other, please specify: _____________
- ☐ Don't know
- ☐ Missing

3-6. On average, how long did the ear infection/s last?

- ☐ A few days (2-3 days)
- ☐ 1-3 weeks
- ☐ At least 1 month
- ☐ Other, please specify: _____________
- ☐ Don't know
- ☐ Missing

3-7. Have you ever received any treatment for your ear infection/s?

- ☐ Yes
- ☐ No (go to Q9)
- ☐ Don't know
- ☐ Missing

3-8. What treatment/s have you ever received for your ear infection/s?

- ☐ Antibiotics
- ☐ Pain killers
- ☐ Other, please specify: ______________
- ☐ Don't know
- ☐ Missing

3-9. In the last 5 years, did you have any ear infections as an adult?

- ☐ Yes
- ☐ No (go to Q3-14)
- ☐ Don't know
- ☐ Missing

3-10. In the last 5 years, how often did you have ear infections as an adult?

- ☐ Once
- ☐ At least once a year
- ☐ Once every few years
- ☐ Other, please specify: _____________
- ☐ Don't know
- ☐ Missing

3-11. How long do the ear infection/s last?

- ☐ A few days (2-3 days)
- ☐ 1-3 weeks
- ☐ At least 1 month
- ☐ Other, please specify: _____________
- ☐ Don't know
- ☐ Missing

3-12. Have you received any treatment for your ear infection/s?

- ☐ Yes
- ☐ No (go to Q3-14)
- ☐ Don't know
- ☐ Missing

3-13. What treatment did you receive for your ear infection/s?

- ☐ Antibiotics
- ☐ Pain killers
- ☐ Other, please specify: ______________
- ☐ Don't know
- ☐ Missing

3-14. In the last 5 years, has a doctor told you that you had a middle ear condition?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

3-15. Has a doctor ever told you that you had sinus infection or chronic sinusitis?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

3-16. Have you experienced any earaches in the last year?

- ☐ Yes
- ☐ No (go to Q3-18)
- ☐ Don't know
- ☐ Missing

3-17. Did this earache affect your:

- ☐ Right ear
- ☐ Left ear
- ☐ Both ears
- ☐ Don't know
- ☐ Missing

3-18. Has either or both of your ears felt blocked in the last year?

- ☐ Yes
- ☐ No (go to Q3-20)
- ☐ Don't know
- ☐ Missing

3-19. Which ear has felt blocked?

- ☐ Right ear
- ☐ Left ear
- ☐ Both ears
- ☐ Don't know
- ☐ Missing

3-20. Have you had a discharge (other than wax) from either ear in the last year?

- ☐ Yes, right ear
- ☐ Yes, left ear
- ☐ Yes, both ears
- ☐ No
- ☐ Don't know
- ☐ Missing

4. Ear surgery, general health

4-1. Have you ever had surgery to your ears?

- ☐ Yes
- ☐ No (go to next page)
- ☐ Don't know
- ☐ Missing

4-2. Which ear had the surgery?

- ☐ Right ear
- ☐ Left ear (go to Q4-5)
- ☐ Both ears
- ☐ Don't know
- ☐ Missing

4-3. What surgery was performed on your right ear? *multiple responses accepted*

- ☐ Mastoidectomy
- ☐ Stapedectomy
- ☐ Tympanoplasty
- ☐ Tubes (Grommets) inserted
- ☐ Myringotomy
- ☐ Other procedure
- ☐ Unsure
- ☐ Missing

4-4. Details: ____

4-5. What surgery was performed on your left ear? *multiple responses accepted*

- ☐ Mastoidectomy
- ☐ Stapedectomy
- ☐ Tympanoplasty
- ☐ Tubes (Grommets) inserted
- ☐ Other procedure
- ☐ Unsure
- ☐ Missing

4-6. Details:____

5. Exposure to ototoxic chemicals

5-1. Have you worked in an industry where you were exposed to chemicals (e.g., freight truck transportation; chemical or food manufacturing; educational services/organisations; utilities such as electricity, gas, water, sewage removal)?

- ☐ Yes
- ☐ No (go to Q6-1)
- ☐ Don't know
- ☐ Missing

5-2. Details ____

5-3. Have you been exposed to chemicals outside of work?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

5-4. Details ____

Have you had frequent contact with any of the following chemicals?

5-5. *Trichloroethylene*

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Missing

5-6. *Toluene*

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

5-7. *Lead*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-8. *Mercury*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-9. *Manganese*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-10. *Arsenic*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-11. *Styrene*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-12. *Carbon disulphide*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-13. *Xylene*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-14. *Other chemicals*
☐ Yes ☐ Don't know
☐ No ☐ Missing

5-15. Details (*other chemicals*) ____

6. Ototoxic medications

Have you ever received treatment for the following diseases/conditions?

6-1. Malaria (quinine)
☐ Yes ☐ Don't know
☐ No ☐ Missing

6-2. Cancer (carboplatinum or cisplatin)
☐ Yes ☐ Don't know
☐ No ☐ Missing

6-3. Fluid build-up due to heart/liver/kidney failure (ethacrynic acid (Edecril) or frusemide (Lasix))
☐ Yes ☐ Don't know
☐ No ☐ Missing

6-4. Tuberculosis (streptomycin or kanamycin)
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

6-5. Bone infections, meningitis, pneumonia, UTIs, sepsis (gentamicin)
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

6-6. Skin infection (neomycin)
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Missing

6-7. Details ____

7. Noise exposure

7-1. Have you ever worked with noisy farm equipment?
- ☐ Yes
- ☐ No (go to Q7-8)
- ☐ Don't know
- ☐ Missing

7-2. Over how long a period did you work with noisy farm equipment?
- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 5 to 10 years
- ☐ More than 10 years
- ☐ Don't know
- ☐ Missing

7-3. Details ____

7-4. How would you describe the noise level from farm equipment that you were exposed to on an average day?
- ☐ Mostly quiet
- ☐ Tolerable but able to hear speech
- ☐ Unable to hear anyone speaking
- ☐ Unsure
- ☐ Missing

7-5. Did you wear hearing protection when working with noisy farm equipment?
- ☐ Yes
- ☐ No (go to Q7)
- ☐ Don't know
- ☐ Missing

7-6. What hearing protection did you wear?
- ☐ Earplugs
- ☐ Earmuffs
- ☐ Both
- ☐ Cotton wool
- ☐ Other
- ☐ Missing

7-7. Did you notice a change in your hearing after this period?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Missing

7-8. Have you ever worked in other noisy industries?
- ☐ Yes
- ☐ No (go to Q7-15)
- ☐ Don't know
- ☐ Missing

7-9. Over what period have you been in jobs or industries with significant noise exposure?
- ☐ Less than 1 year
- ☐ More than 10 years

- ☐ 1-5 years
- ☐ 5 to 10 years
- ☐ Don't know
- ☐ Missing

7-10. Details ____

7-11. How would you describe the noise level you were exposed to on an average day?
- ☐ Mostly quiet
- ☐ Tolerable but able to hear speech
- ☐ Unable to hear anyone speaking
- ☐ Unsure
- ☐ Missing

7-12 On average, at these times of noise exposure, how often would you wear hearing protection?
- ☐ Always
- ☐ Rarely
- ☐ Sometimes
- ☐ Don't know
- ☐ Missing
- ☐ Never (go to Q7-14)

7-13. What hearing protection did you wear?
- ☐ Earplugs
- ☐ Earmuffs
- ☐ Both
- ☐ Cotton wool
- ☐ Other
- ☐ Missing

7-14. Did you notice a change in your hearing after this period?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Missing

7-15. Have you ever been a member of the military?
- ☐ Yes
- ☐ No (go to Q7-17)
- ☐ Don't know
- ☐ Missing

7-16. Details ____

7-17. Have you been exposed to gunfire or explosions?
- ☐ Yes
- ☐ No (go to Q7-25)
- ☐ Don't know
- ☐ Missing

7-18. Was this in association with:
- ☐ Cadet
- ☐ Military/police force
- ☐ Recreational
- ☐ Other
- ☐ Missing

7-19. Details ____

7-20. Over how long a period were you exposed to gunfire or explosions?
- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 5 to 10 years
- ☐ More than 10 years
- ☐ Missing

7-21. Were you exposed for:
- ☐ Less than once per year
- ☐ 1-2 times per years
- ☐ 3-12 times per years
- ☐ More than 12 times per year
- ☐ Once or more times per week
- ☐ Missing

7-22. Did you wear hearing protection?

☐ Yes
☐ No (go to Q7-24)
☐ Unsure
☐ Missing

7-23. What hearing protection did you wear?

☐ Earplugs
☐ Earmuffs
☐ Both
☐ Cotton wool
☐ Other
☐ Missing

7-24. Did you notice a change in your hearing after this period?

☐ Yes
☐ No
☐ Unsure
☐ Missing

Have you done any of the following types of work or activities on a regular basis?

7-25. musician or played an instrument

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-26. woodworking

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-27. carpentry

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-28. sheet metalwork

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-29. chain sawing

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-30. used power tools

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-31. driven racing cars/worked with them

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-32. listened to a personal audio device (e.g., mobile phone) through headphones/earbuds at a volume loud enough that you need to raise your voice

☐ Yes
☐ No
☐ Unsure
☐ Missing

7-33. listed to a stereo in a car or at home at a volume loud enough that you need to raise your voice

☐ Yes ☐ Unsure
☐ No ☐ Missing

7-34. attended rock concerts or bands regularly

☐ Yes ☐ Unsure
☐ No ☐ Missing

7-34. attended or hosted a house party

☐ Yes ☐ Unsure
☐ No ☐ Missing

8. Illnesses affecting hearing

Did you ever have any of the following infections or conditions?

8-1. Mumps

☐ Yes ☐ Unsure
☐ No ☐ Missing

8-2. Measles

☐ Yes ☐ Unsure
☐ No ☐ Missing

8-3. Rubella (German measles)

☐ Yes ☐ Unsure
☐ No ☐ Missing

8-4. Mastoiditis

☐ Yes ☐ Unsure
☐ No ☐ Missing

8-5. Otosclerosis

☐ Yes ☐ Unsure
☐ No ☐ Missing

9. Health Outcomes – EuroQOL Group EQ-5D-5L

By placing a tick in one box in each group below, please tick which statements best describe your own health state today.

9-1. Mobility
☐1 I have no problems in walking about
☐2 I have slight problems in walking about
☐3 I have moderate problems in walking about
☐4 I have severe problems in walking about
☐5 I am unable to walk about

9-2. Self-Care
☐1 I have no problems washing or dressing myself
☐2 I have slight problems washing or dressing myself
☐3 I have moderate problems washing or dressing myself
☐4 I have severe problems washing or dressing myself
☐5 I am unable to wash or dress myself

9-3. Usual Activities *(e.g. work, study, housework, family or leisure activities)*
☐1 I have no problems doing my usual activities
☐2 I have slight problems doing my usual activities
☐3 I have moderate problems doing my usual activities
☐4 I have severe problems doing my usual activities
☐5 I am unable to do my usual activities

9-4. Pain
☐1 I have no pain or discomfort
☐2 I have slight pain or discomfort
☐3 I have moderate pain or discomfort
☐4 I have severe pain or discomfort
☐5 I have extreme pain or discomfort

9-5. Anxiety / Depression
☐1 I am not anxious or depressed
☐2 I am slightly anxious or depressed
☐3 I am moderately anxious or depressed
☐4 I am severely anxious or depressed
☐5 I am extremely anxious or depressed

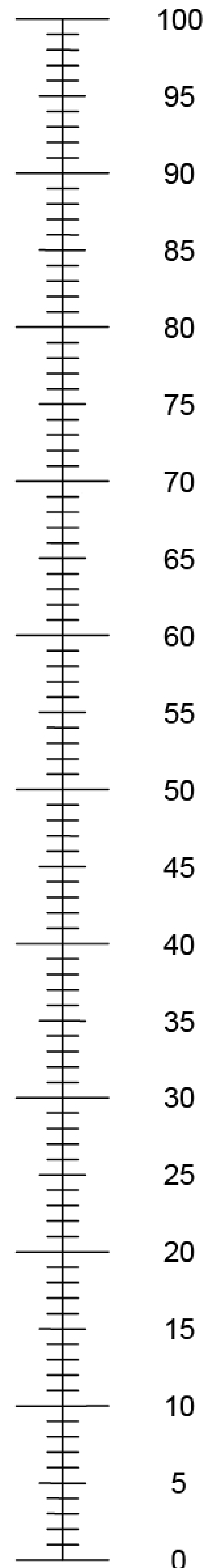
Health Outcomes – EQ-5D Visual Analogue Scale

9-6. We would like to know how good or bad your health is today.

This scale is numbered from 0 to 100.
  100 means the **best** health you can imagine.
  0 means the **worst** health you can imagine.
Mark an X on the scale to indicate how your health is today.

Now, please write the number you marked on the scale in the box below.

Your health today = _______________



10. Fatigue Severity Scale

Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

During the past week, I have found that:	Disagree		⟷			Agree	
10-1. My motivation is lower when I am fatigued	1	2	3	4	5	6	7
10-2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
10-3. I am easily fatigued.	1	2	3	4	5	6	7
10-4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
10-5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
10-6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
10-7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
10-8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
10-9. Fatigue interferes with my work, family or social life.	1	2	3	4	5	6	7

11. IPEQ Incidental and Planned Exercise Questionnaire

In the past three months, how much time did you spend in the following activities on average per week?

Exercise Type	No. of times/wk	Duration per session				
		<30 mins	30-45 mins	45-60 mins	1-2hrs	2-4hrs
11-1. Exercise class		☐1	☐2	☐3	☐4	☐5
11-2. Home exercise (e.g. stationary bike, stretching)		☐1	☐2	☐3	☐4	☐5
11-3. Other exercise* 1 (please specify)		☐1	☐2	☐3	☐4	☐5
11-4. Other exercise* 2 (please specify)		☐1	☐2	☐3	☐4	☐5
11-5. Other exercise* 3 (please specify)		☐1	☐2	☐3	☐4	☐5

**Examples of other exercise: bowls, golf, tennis, swimming, dancing, jogging, bicycling etc.*

11-6. During the past three months, how often have you been on walks specifically for exercise on average per week? (i.e. walking in the park, in the streets, cross-country walking, walking the dog etc).

☐1 Every day
☐2 3-6 times/week
☐3 Twice/week
☐4 Once/week
☐5 Less than once/week
☐6 Never (Go to Q7)

11-7. In these walks for Exercise, how long did you walk for?

☐1 Less than 15 mins/day
☐2 15mins to less than 30mins/day
☐3 30mins to less than 1hr/day
☐4 1hr to less than 2hrs/day
☐5 2hrs to less than 4hrs/day
☐6 4 or more hours/day

11-8. During the past three months, how often have you been on other walks (i.e. walk to general practitioner, pharmacy, or store) on average per week?

☐1 Every day
☐2 3-6 times/week
☐3 Twice/week
☐4 Once/week
☐5 Less than once/week
☐6 Never (Go to Q9)

11-9. In these other walks, how long did you walk for?
- ☐1 Less than 15 mins/day
- ☐2 15mins to less than 30mins/day
- ☐3 30mins to less than 1hr/day
- ☐4 1hr to less than 2hrs/day
- ☐5 2hrs to less than 4hrs/day
- ☐6 4 or more hours/day

11-10. In the past three months, in addition to the walking you mentioned above, how much time did you spend each day out of your house doing other physical activity such as house maintenance and gardening? (Excluding housework and activities inside the house).
- ☐1 Never (i.e. no garden)
- ☐2 Less than 15 mins/day
- ☐3 15mins to less than 30mins/day
- ☐4 30mins to less than 1hr/day
- ☐5 1hr to less than 2hrs/day
- ☐6 2hrs to less than 4hrs/day
- ☐7 4 or more hours/day

11-12. In the past three months, how many hours did you spend on your feet each day indoors at home doing tasks like housework, self care or care for another person?
- ☐1 Never (i.e. living in hostel, assisted living)
- ☐2 Less than 15 mins/day
- ☐3 15mins to less than 30mins/day
- ☐4 30mins to less than 1hr/day
- ☐5 1hr to less than 2hrs/day
- ☐6 2hrs to less than 4hrs/day
- ☐7 4 or more hours/day

Thank you very much for your help

We know that completing this questionnaire has required a lot of your valuable time and effort.

We greatly appreciate your contribution to this Australian Eye and Ear Health Survey.