Patient ID | | | | | | | | | DOB | | | |

LiGHT Trial- Laser in Glaucoma and Ocular Hypertension

QUESTIONNAIRE BOOKLET- Twenty fourth month

In the UK glaucoma affects over half a million individuals. The LiGHT trial is one of the largest studies in this country assessing effective ways of treating Glaucoma and its effects on individuals. For this study to be successful and to give us valuable information about Glaucoma and how to improve people's lives, we need your help.

We would be grateful if you could take the time to fill in this booklet as part of the LiGHT trial. You may think some of the questions do not seem related to you, but they have all been specially chosen because they measure significant and important effects of Glaucoma and its treatment. Your answers will help us to find which treatment pathway used in the LiGHT trial leads to a better health related quality of life.

Each of the sections covers a different area and there is an explanation at the beginning of each of the sections.

As you will see there are quite a lot of questions, but please do not be put off as most of them are very straightforward. Some of the questions do overlap or ask similar things. We know about this, but would ask you to fill them all in as the questions are very important to the outcome of the trial.

You do not have to fill in the booklet in one go. If you want you can take a break and come back to it later. It is easier to complete the booklet in a quiet place, and at a time of day when you are not too busy.

All of the information you provide is confidential and Anonymous.

Please send the completed booklet back to us in the stamped addressed envelope provided.

NHS National Institute for Health Research

LiGHT

If you have any questions or concerns please contact:

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Please send the Questionnaire Booklet back by

in the pre-paid stamp envelope provided

1 EuroQol questionnaire

We are asking you the following questions to see how you rate your own health. For each of the following questions please place a tick in the box that closest describes your state of health **TODAY**.

1 Please indicate your level of mobility *(please tick **one** box)*

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

2 Please indicate your level of self-care (*please tick **one** box)*

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3 Please indicate your ability to perform your usual activities e.g. work, study, housework, family or leisure activities (*please tick **one** box)*

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

4 Please indicate your level of pain (*please tick **one** box)*

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

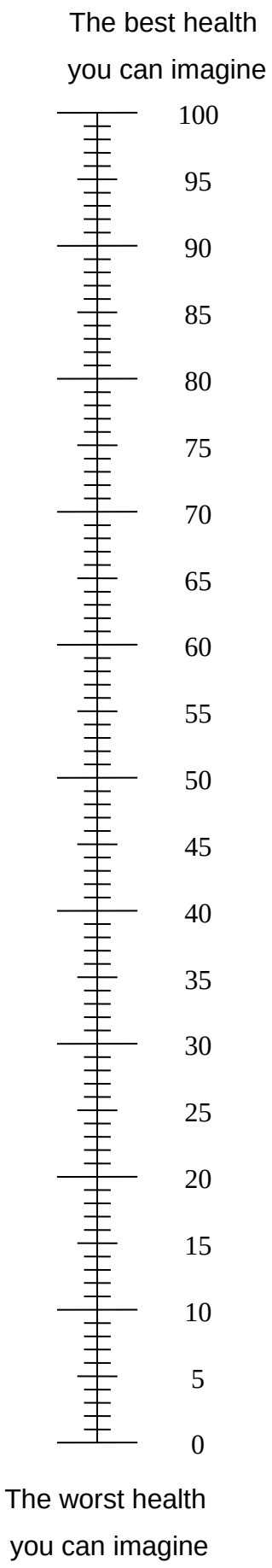
5 Please indicate your level of anxiety or depression (*please tick **one** box)*

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

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 =



2 Glaucoma Utility Index

"*Tick one* box, for each of the categories 1-6, which best describes any difficulties you have had **in the last month** with your eyes or vision, wearing your usual glasses or contact lenses. Under each category there is an example, to help you answer these questions."

	Level of difficulty			
Domains	**No difficulty**	**Some difficulty**	**Quite a lot of difficulty**	**Severe difficulty**
1. Central and Near Vision For example difficulties with reading, writing, watching TV, reading dials on clocks?	☐	☐	☐	☐
2.Lighting and glare For example difficulties with adjusting from light to dark and vice-versa, bright lights may dazzle, difficulties seeing in dim light?	☐	☐	☐	☐
3. Mobility For example difficulties with crossing roads, walking along busy pavements, tripping into low objects e.g. pushchairs?	☐	☐	☐	☐
4. Activities of daily living For example difficulties in seeing adequately to do domestic, DIY or self-care tasks around the home?	☐	☐	☐	☐
5. Eye discomfort For example difficulties with gritty, sore, tired eyes?	☐	☐	☐	☐
5. Other effects For example fatigue, shortness of breath, dry mouth, bitter taste etc?	☐	☐	☐	☐

3. Glaucoma Symptom Scale

Have you experienced any of the following problems with your eyes **in the last 4 weeks**? (Please *tick* a box below for each symptom). If your answer is '*yes'* please tick how bothersome it is.

1 Burning, Smarting, Stinging

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

2 Tearing ("Watering Eyes")

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

3 Dryness

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

Glaucoma Symptom Scale continued …..

4 Itching

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

5 Soreness, Tiredness

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

6 Blurry/dim vision

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

Glaucoma Symptom Scale continued …..

7 Feeling of something in your eye

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

8 Hard to see in daylight

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

9 Hard to see in dark places

No ☐, Go to next question **Yes** ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

Glaucoma Symptom Scale continued …..

10 Halos around lights

No ☐

Yes ☐, How bothersome is it?

Very ☐

Somewhat ☐

A little ☐

Not at all ☐

4. The Glaucoma Quality of Life-15 Questionnaire

Please *Tick one* box, for each of the categories 1-15, which best describes any difficulties you have had in **the last month**, even with your usual glasses or contact lenses.

Activities	None	A little bit of difficulty	Some difficulty	Quite a lot difficulty	Severe difficulty	Do not perform for non visual reasons
1. Reading newspapers	☐	☐	☐	☐	☐	☐
2. Walking after dark	☐	☐	☐	☐	☐	☐
3. Seeing at night	☐	☐	☐	☐	☐	☐
4. Walking on uneven ground	☐	☐	☐	☐	☐	☐
5. Adjusting to bright lights	☐	☐	☐	☐	☐	☐
6. Adjusting to dim lights	☐	☐	☐	☐	☐	☐
7. Going from light to dark room or vice versa	☐	☐	☐	☐	☐	☐
8. Tripping over objects	☐	☐	☐	☐	☐	☐
9. Seeing objects coming from the side	☐	☐	☐	☐	☐	☐
10. Crossing the road	☐	☐	☐	☐	☐	☐
11. Walking up steps/stairs	☐	☐	☐	☐	☐	☐
12. Bumping into objects	☐	☐	☐	☐	☐	☐
13. Judging distance of foot to step/curb	☐	☐	☐	☐	☐	☐
14. Finding dropped objects	☐	☐	☐	☐	☐	☐
15.Recognizing faces	☐	☐	☐	☐	☐	☐

5. The following questions will help Moorfields Eye Hospital collect information about healthcare costs.

1 **In the last 6 months** have you been in contact with any of the health care services below? If yes please write the number of times below.

Eye related services

1A Opticians

No	Yes	Number of times
☐	☐	……

1B Hospital eye clinic

No	Yes	Number of times
☐	☐	……..

2 **in the last 6 months** have you been admitted to any of the below services? If *'yes'* please enter the number of admissions & total number of nights stay in hospital.

Specialist/Acute hospital services

2A Overnight in-patient stay			
No, Go to question 2B ☐	**Yes** ☐		
2A1 Planned in-patient admission		**Number of admissions**	**Total number of nights**
No ☐	**Yes** ☐	No. =	No. =
2A2 Emergency in-patient admission			
No ☐	**Yes** ☐	No. =	No. =
2A3 Intensive care/high dependency unit			
No ☐	**Yes** ☐	No. =	No. =
2B Day patient procedure/test		**Total number of contacts in the last 6 months**	
No ☐	**Yes** ☐	No. =	No. =
2C Outpatient appointment			
No ☐	**Yes** ☐	No. =	No. =
2D Accident and Emergency attendance			
No, Go to question 3 ☐	**Yes** ☐		
2D1 And admitted to hospital		Total number of contacts **in the last 6 months**	
No ☐	**Yes** ☐	No. =	
2D2 Not admitted to hospital			
No ☐	**Yes** ☐	No. =	

Please check you have answered all questions and turn over Version 4.3, 8th January 2014

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3. In the last 6 months, have you used any of the services below? If *'yes'* please enter the number of times you have visited the services below for eye related and non eye related conditions

General Practitioner (GP) and community services

3A GP Contacts

No, Go to question 3B ☐ **Yes** ☐

Total number of contacts in the last **6 months**

		Eye Related	Not eye related
3A1 In the practice	**No** ☐ **Yes** ☐	No. = ☐	No. = ☐
3A2 Telephone consultation	**No** ☐ **Yes** ☐	No. = ☐	No. = ☐
3A3 Home visit	**No** ☐ **Yes** ☐	No. = ☐	No. = ☐

3B GP Practice Nurse

No ☐ **Yes** ☐ No. = ☐ No. = ☐

3C Social Worker

No ☐ **Yes** ☐ No. = ☐ No. = ☐

3D Home care worker

No ☐ **Yes** ☐ No. = ☐ No. = ☐

3E Other Community services

Please give details:_____ No. = ☐ No. = ☐

Please check you have answered all questions and turn over Version 4.3, 8th January 2014

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4 **In the last 6 months**, have you taken any medication?

No ☐ **Yes** ☐

If yes, what medications have you been taking. Please list below all medications taken (tablets, pills, capsules and all medicines) in the last 6 months

MEDICATION				
DRUG NAME	**DURATION OF USE**		**DOSAGE**	
Trade name OR medical name OR name on packet	Please TICK if CONTINOUS	If NOT CONTINOUS please state NO. OF DAYS TAKEN FOR	DOSE TAKEN	NO. TAKEN PER DAY
E.g. Metformin	✓		500mg	2
E.g. Paracetamol		3 days	500mg	3

5. Do you have private health insurance?

Private Health Insurance

No ☐ **Yes** ☐

If *'yes'* please **list below** the health care services you accessed **in the last 6 months** through your private health insurance:

6 Concordance / Compliance

1 Over the last month, what percentage or proportion of your eye drops do you think you took correctly? Please write in the boxes below or mark *X* on the scale.

Not applicable

Percentage (%) or proportion taken correctly

%	Proportion
100%	All
75 %	¾
50%	½
25%	¼
0	None

2 Please read the below statement and *tick* the box which you agree with.

"I'm the sort of person who follows doctors' orders exactly."

Statement	**Please tick one box**
Strongly agree	☐
Somewhat agree	☐
Neither agree nor disagree	☐
Somewhat disagree	☐
Strongly disagree	☐

THANK YOU FOR COMPLETING THE QUESTIONNAIRES IN THIS BOOKLET.

If you have any further comments you wish to make please do so below.

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in the pre-paid stamp envelope provided

Please check you have answered all questions and turn over