

EYE PAIN IMPACT QUESTIONNAIRE

ID. No.: subjid Alpha Code: alpha_code Visit #: epvisit

NOTE: To be completed at the baseline visit, the week 4 visit, and the 6 and 12 month visits. The study team should read the questions to the subject and record their answers.

“I am going to ask you how often, if any, eye pain affects your activities. I will read the choice of four answers and you will choose the one that describes you best.”

	A. RIGHT EYE				B. LEFT EYE			
	Never	Occasionally	Often	Constantly	Never	Occasionally	Often	Constantly
1. In the last month, how often has eye pain interfered with your personal care such as bathing, eating, and dressing?	1 <u>epcare_r</u>	2	3	4	1 <u>epcare_l</u>	2	3	4
2. In the last month, how often has eye pain disturbed your sleep?	1 <u>epsleep_r</u>	2	3	4	1 <u>epsleep_l</u>	2	3	4
3. In the last month, how often has eye pain interfered with your household work such as cooking, house cleaning, washing cloth, fetching water, fetching firewood, caring to other family members?	1 <u>ephousework_r</u>	2	3	4	1 <u>ephousework_l</u>	2	3	4
4. In the last month, how often has eye pain affected your non-household work, such as agricultural or paid work?	1 <u>eppaidwork_r</u>	2	3	4	1 <u>eppaidwork_l</u>	2	3	4
5. In the last month, how often has eye pain affected your participation in social activities such as attending weddings, social meetings, and funerals?	1 <u>epsocial_r</u>	2	3	4	1 <u>epsocial_l</u>	2	3	4

6. Name & certification number of study team member completing form

a. Print Name: _____

b. Certification #: _____

7. Date form completed:

____ / ____ / ____

Day Month Year

Data entry complete date: ____ / ____ / ____

Data entered by initials: ____