The Genetics of Blindness

Record ID	_____
Type of Case	◯ Case ◯ Control
Date of Examination	_____
Identifier Code	_____
Specimen Number	_____
Case Note Number	_____
Collection of Sample Date	_____
What is your birth date?	◯ Enter Birth Date ◯ Don't Know ◯ Prefer Not to Answer
MM/DD/YYYY	_____
About how old are you?	◯ Enter age ◯ Don't Know ◯ Prefer Not to Answer
Age	_____ (Years)
Are you male or female?	◯ Male ◯ Female ◯ Prefer Not to Answer ◯ Don't Know

	No formal education	Quranic education	Primary education	Secondary education	Tertiary education	Other
Educational Level	◯	◯	◯	◯	◯	◯

Other education level	_____
Occupational status	◯ Employed ◯ Unemployed
What is your occupation?	_____
Domicile	_____

In which country were you and your parents born?

	Nigeria	Ghana	Kenya	South Africa	Other African Country	Other non-African Country
You	○	○	○	○	○	○
Your Mother	○	○	○	○	○	○
Your Father	○	○	○	○	○	○

In which African country were you born?

_____

In which non-African country were you born?

_____

In which African country was your mother born?

_____

In which non-African country was your mother born?

_____

In which African country was your father born?

_____

In which non-African country was your father born?

_____

What is the main language spoken by you and your parents?

	Yoruba	Igbo	Hausa	Efik	Itsekiri	Fulani	Calabar	Other
You	○	○	○	○	○	○	○	○
Your Mother	○	○	○	○	○	○	○	○
Your Father	○	○	○	○	○	○	○	○

What is the main language spoken by you?

_____

What is the main language spoken by your mother?

_____

What is the main language spoken by your father?

_____

What is your and your parent's ethnic or tribal affiliation?

	Itsekiri	Idoma	Fulani	Yoruba	Calaba	Urhobo	Hausa	Ibibio	Igbo	Other
You	○	○	○	○	○	○	○	○	○	○
Your Mother	○	○	○	○	○	○	○	○	○	○
Your Father	○	○	○	○	○	○	○	○	○	○

What is your ethnic or tribal affiliation?

_____

What is your mother's ethnic or tribal affiliation?

_____

What is your father's ethnic or tribal affiliation?

_____

Standing Height

What is your standing height? Please select appropriate units and measure your height two times.

◯ Inches ◯ Centimeters

Standing Height 1

_____
(Inches)

Standing Height 2

_____
(Inches)

Standing Height 3

_____
(Inches)

Standing Height Average

_____
(Inches)

Standing Height 1

_____
(Centimeters)

Standing Height 2

_____
(Centimeters)

Standing Height 3

_____
(Centimeters)

Standing Height Average

_____
(Centimeters)

Measured Weight

What is your weight? Please select the appropriate units and measure your weight twice.

◯ lbs ◯ kg

Are you wearing a cast or medical prosthesis?

◯ Yes ◯ No

Where is your cast or medical prosthesis located?

_____

Are you wearing street clothes?

◯ Yes ◯ No

Measured Weight 1

_____ (lbs)

Measured Weight 2

_____ (lbs)

Measured Weight 3

_____ (lbs)

Average Measured Weight

_____ (lbs)

Measured Weight 1

_____ (kg)

Measured Weight 2

_____ (kg)

Measured Weight 3

_____ (kg)

Average Measured Weight

_____ (kg)

Blood Pressure

Has a doctor ever said that you have high blood pressure or hypertension? ◯ Yes ◯ No ◯ Not Sure

At what age were you first told this?

_____

Was this during pregnancy only?

_____

Have you ever taken medication for hypertension/high blood pressure? ◯ Yes ◯ No ◯ Not Sure

At what age did you begin taking medicine for this? ◯ Age ◯ Not Sure

Age

_____

Are currently taking medication for hypertension/high blood pressure? ◯ Yes ◯ No

Aneroid Sphygmomanometers Name	_____
Aneroid Sphygmomanometers Model	_____
Blood pressure cuffs size	◯ S ◯ M ◯ L ◯ XL
Systolic Pressure Measurement 1	_____
Diastolic Pressure Measurement 1	_____
Systolic Pressure Measurement 2	_____
Diastolic Pressure Measurement 2	_____
Systolic Pressure Measurement 3	_____
Diastolic Pressure Measurement 3	_____
Date of Measurement(s)	_____

Tobacco

Have you smoked at least 100 cigarettes in your entire life?	◯ Yes ◯ No ◯ Don't Know

	Every Day	Some Days	Not at All	Don't Know	Prefer Not to Answer
How often do you smoke?	◯	◯	◯	◯	◯

Have you EVER smoked cigarettes EVERY DAY for at least 6 months?	◯ Yes ◯ No ◯ Don't Know
How old were you when you first started smoking cigarettes every day?	◯ Enter age ◯ Don't Know
Age	_____
How old were you when you first started smoking cigarettes FAIRLY REGULARLY?	◯ Enter age ◯ Don't Know
Age	_____

On the average, about how many cigarettes do you now smoke each day?	◯ Enter number ◯ Don't Know ◯ Prefer Not to Answer
Number of cigarettes per day	_____
On how many of the past 30 days did you smoke cigarettes?	◯ Enter number ◯ Don't Know ◯ Prefer Not to Answer
Number of days	_____
On the average, on the days you smoked, how many cigarettes did you usually smoke each day?	◯ Enter number ◯ Don't Know ◯ Prefer Not to Answer
Number of cigarettes smoked per day	_____
Have you EVER smoked cigarettes EVERY DAY for at least 6 months?	◯ Yes ◯ No ◯ Don't Know ◯ Prefer Not to Answer
When you last smoked every day, on average how many cigarettes did you smoke each day?	◯ Enter number ◯ Don't Know ◯ Prefer Not to Answer
Number of cigarettes per day	_____
When you last smoked fairly regularly, on average how many cigarettes did you smoke each day?	◯ Enter number ◯ Don't Know ◯ Prefer Not to Answer
Number of cigarettes per day	_____

	Enter days	Enter weeks	Enter months	Enter years	Don't Know	Prefer Not to Answer
About how long has it been since you COMPLETELY quit smoking cigarettes?	◯	◯	◯	◯	◯	◯
Days			_____			
Weeks			_____			
Months			_____			
Years			_____			

In your ENTIRE LIFE, have you ever

Smoked at least 50 cigars?	◯ Yes ◯ No ◯ Don't Know ◯ Prefer Not to Answer
Smoked a pipe at least 50 times?	◯ Yes ◯ No ◯ Don't Know ◯ Prefer Not to Answer
Used snuff, [such as Skoal?, Skoal Bandit? or Copenhagen?] at least 20 times?	◯ Yes ◯ No ◯ Don't Know ◯ Prefer Not to Answer
Used chewing tobacco, [such as Redman?, Levi Garrett? or Beechnut?] at least 20 times?	◯ Yes ◯ No ◯ Don't Know ◯ Prefer Not to Answer

Alcohol

In your entire life, have you had at least 1 drink of any kind of alcohol, not counting small tastes or sips?	◯ Yes ◯ No ◯ Don't Know ◯ Prefer Not to Answer
About how old were you when you first started drinking, not counting small tastes or sips of alcohol?	◯ Age ◯ Never drank
Age	_____
During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	◯ Enter number of days ◯ Don't Know ◯ Prefer Not to Answer
Number of days	_____
On the days that you drank during the past 30 days, how many drinks did you usually have each day? Count as a drink a can or bottle of beer; a wine cooler or a glass of wine, champagne, or sherry; a shot of liquor or a mixed drink or cocktail.	◯ Enter number of drinks ◯ Don't Know ◯ Prefer Not to Answer
Number of drinks	_____
What was the LARGEST number of drinks that you ever drank in a single day?	◯ Enter number ◯ Don't Know ◯ Prefer Not to Answer
Largest number of drinks in a single day	_____

Have you ever used any of the following?	
Sedatives	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use sedatives?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Tranquilizers	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use tranquilizers?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Painkillers	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use painkillers?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Stimulants	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use stimulants?	◯ Enter number of days ◯ Don't Know
Number of days	_____

Marijuana, Hash, HC, or Grass	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use marijuana, hash, HC, or grass?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Cocaine	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use cocaine?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Crack Cocaine	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use crack cocaine?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Hallucinogens	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use hallucinogens?	◯ Enter number of days ◯ Don't Know
Number of days	_____

Inhalants	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use inhalants?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Heroin	◯ Yes ◯ No ◯ Don't Know
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use heroin?	◯ Enter number of days ◯ Don't Know
Number of days	_____
Any other medicines, drugs, or substances?	◯ Yes ◯ No ◯ Don't Know
Name of other medicine, drug, or substance	_____
Age at first use	◯ Enter Age ◯ Don't Know
Age	_____
How many days in the last 30 days did you use this medicine, drug, or substance?	◯ Enter number of days ◯ Don't Know
Number of days	_____

Has a doctor ever told you that you had any of the following conditions?

	Yes	No	Don't Know	Refuse to Answer
High blood pressure	◯	◯	◯	◯

At what age were you told that you have high blood pressure?	_____

	Yes	No	Don't Know	Refuse to Answer
High cholesterol (high fat in your blood)	○	○	○	○

At what age were you told that you have high cholesterol (high fat in your blood)? _____

	Yes	No	Don't Know	Refuse to Answer
Heart attack	○	○	○	○

At what age were you told that you have had a heart attack? _____

	Yes	No	Don't Know	Refuse to Answer
Arrhythmia (irregular heart beats)	○	○	○	○

At what age were you told that you have an arrhythmia (irregular heart beats)? _____

	Yes	No	Don't Know	Refuse to Answer
Asthma or wheezing	○	○	○	○

At what age were you told that you have asthma or wheezing? _____

	Yes	No	Don't Know	Refuse to Answer
Stroke	○	○	○	○

At what age were you told that you have had a stroke? _____

	Yes	No	Don't Know	Refuse to Answer
Kidney disease	○	○	○	○

At what age were you told that you have kidney disease? _____

	Yes	No	Don't Know	Refuse to Answer
Diabetes/High blood sugar	○	○	○	○

At what age were you told that you have diabetes or high blood sugar? _____

	Yes	No	Don't Know	Refuse to Answer
Cancer	○	○	○	○

At what age were you told that you have cancer? _____

Where did the cancer start? _____

	Yes	No	Don't Know	Refuse to Answer
Schizophrenia	◯	◯	◯	◯

At what age were you told that you have schizophrenia? _____

	Yes	No	Don't Know	Refuse to Answer
Tuberculosis (TB)	◯	◯	◯	◯

At what age were you told that you have tuberculosis (TB)? _____

	Yes	No	Don't Know	Refuse to Answer
Sleeping sickness	◯	◯	◯	◯

At what age were you told that you have sleeping sickness? _____

	Yes	No	Don't Know	Refuse to Answer
AIDS (HIV)	◯	◯	◯	◯

At what age were you told that you have AIDS (HIV)? _____

	Yes, now	Yes, not now	No	Maybe	Don't Know
Are you taking any anticoagulants (Coumadin, Warfarin, etc.)?	◯	◯	◯	◯	◯

History of Stroke - Ischemic Infarction and Hemorrhage

Were you ever told by a doctor you had a stroke?	◯ Yes	◯ No	◯ Don't Know
Were you ever told by a doctor you had a TIA, ministroke, or transient ischemic attack?	◯ Yes	◯ No	◯ Don't Know
Have you ever had a sudden painless weakness on one side of your body?	◯ Yes	◯ No	◯ Don't Know
Have you ever had a sudden numbness or a dead feeling on one side of your body?	◯ Yes	◯ No	◯ Don't Know
Have you ever had a sudden painless loss of vision in one or both eyes?	◯ Yes	◯ No	◯ Don't Know
Have you ever suddenly lost one half of your vision?	◯ Yes	◯ No	◯ Don't Know
Have you ever suddenly lost the ability to understand what people are saying?	◯ Yes	◯ No	◯ Don't Know

Have you ever suddenly lost the ability to express yourself verbally or in writing? ◯ Yes ◯ No ◯ Don't Know

Personal History of Kidney Failure

Has a doctor ever told you that you had kidney failure? ◯ Yes ◯ No ◯ Don't Know

Are one or both kidneys working well now? ◯ Yes ◯ No ◯ Don't Know

How old were you when you were first told by a doctor that you had kidney failure? Indicate the actual age. _____

Are you currently on renal dialysis? ◯ Yes ◯ No ◯ Don't Know

Have you ever had a kidney transplant? ◯ Yes ◯ No ◯ Don't Know

Has anyone in your family had kidney disease or died from kidney disease (not a urinary tract infection)? ◯ Yes ◯ No ◯ Don't Know

Do you know the type of kidney disease? ◯ Yes ◯ No

What type of kidney disease did your family member have? _____

Has a doctor told you your kidneys have low function? ◯ Yes ◯ No ◯ Don't Know

Has a doctor told you your kidneys have low function? ◯ Yes ◯ No ◯ Don't Know

Have you ever had a urine test? ◯ Yes ◯ No ◯ Don't Know

When did you have a urine test? _____

Where did you have a urine test? _____

Do you know the doctor's name that performed the urine test? ◯ Yes ◯ No ◯ Don't Know

Please enter the name of the Doctor _____

	Phone Number	Email	Address	Don't Know	Can't Remember
Please enter the contact information for the doctor	☐	☐	☐	☐	☐

Doctor's Phone Number _____

Doctor's Email

Doctor's Address

Has your doctor or health care professional told you that you had diabetes?	◯ Yes ◯ No ◯ Don't Know
Are you taking medicine for this?	◯ Yes ◯ No ◯ Don't Know
What kind of medicine are you taking?	◯ Insulin ◯ Pills
At what age was this first treated?	◯ Enter age ◯ Don't Know
Enter age	
Was insulin your first diabetes medicine?	◯ Yes ◯ No ◯ Don't Know
Did diabetes occur ONLY during Pregnancy?	◯ Yes ◯ No ◯ Don't Know

Self-report of Human Immunodeficiency Virus Testing

Have you ever been tested for HIV?	◯ Yes ◯ No ◯ Don't Know
When did you have your most recent HIV test?	
Month	◯ Unknown ◯ January ◯ February ◯ March ◯ April ◯ May ◯ June ◯ July ◯ August ◯ September ◯ October ◯ November ◯ December
Year	

	Negative	Positive	Never obtained results	Indeterminate	Prefer not to answer	Don't know
What was the result of your most recent HIV test?	◯	◯	◯	◯	◯	◯

Is hypertension in your family history?	◯ Yes ◯ No ◯ Don't Know
Is stroke in your family history?	◯ Yes ◯ No ◯ Don't Know
Are you attending any of the clinics in UCH?	◯ Yes ◯ No
Which clinic are you attending?	_____
Are you attending any other clinic outside of UCH?	◯ Yes ◯ No
Which non-UCH clinic are you attending?	_____

Family history of glaucoma?	◯ Yes ◯ No
Who?	◯ Mother ◯ Father ◯ Brother ◯ Sister ◯ Cousin ◯ Aunt ◯ Uncle ◯ Niece ◯ Nephew ◯ Grandmother ◯ Grandfather ◯ Other
Other Family Member	_____

Visual Acuity

Unaided - Right Eye	_____
Unaided - Left Eye	_____
Best Corrected - Right Eye	_____
Best Corrected - Left Eye	_____

Auto-Refraction

	Seen	Not Seen
Target - Right Eye	◯	◯
Target - Left Eye	◯	◯

sph - Right Eye

_____

sph - Left Eye

_____

cyl - Right Eye

_____

cyl - Left Eye

_____

axis - Right Eye

_____

axis - Left Eye

_____

What is responsible for poor/reduced vision in the Right Eye? ◯ Glaucoma ◯ Other

	Cataract	Uveitis	Age related Macular degeneration	Diabetic retinopathy	Other
Other condition responsible for poor/reduced vision in the Right Eye	◯	◯	◯	◯	◯

Specify Other

_____

What is responsible for poor/reduced vision in the Left Eye? ◯ Glaucoma ◯ Other

	Cataract	Uveitis	Age related Macular degeneration	Diabetic retinopathy	Other
Other condition responsible for poor/reduced vision in the Left Eye	◯	◯	◯	◯	◯

Specify Other

_____

IOP as of now

	Possible	Not Possible
Right Eye	◯	◯
Left Eye	◯	◯

IOP 1 - Right Eye

_____ (mmHG)

IOP 1 - Left Eye

_____ (mmHG)

Date - Right Eye

_____

Date - Left Eye

_____

IOP 2 -Right Eye

_____ (mmHG)

IOP 2 - Left Eye

_____ (mmHG)

Date - Right Eye

_____

Date - Left Eye

_____

Highest IOP ever recorded - Right Eye

_____ (mmHG)

Date - Right Eye

_____

Highest IOP ever recorded - Left Eye

_____ (mmHG)

Date - Left Eye

_____

With medication?

◯ Yes
◯ No

Vertical Cup to Disc Ratio

Fundoscopy

	Possible	Not Possible
Right Eye	◯	◯
Left Eye	◯	◯

Vertical Cup to Disc Ratio - Right Eye

_____

Vertical Cup to Disc Ratio - Left Eye

_____

Horizontal Cup to Disc Diameter

Horizontal Cup to Disc Diameter - Right Eye

_____

Horizontal Cup to Disc Diameter - Left Eye

_____

Gonioscopy

	Open angle	Closed angle	Narrow angle
Right Eye	◯	◯	◯
Left Eye	◯	◯	◯

	Pigments in Angles	Synechiae	Blood in Schlemms Canal	Other	None
Other findings on gonioscopy - Right Eye	◯	◯	◯	◯	◯

Other

_____

	Pigments in Angles	Synechiae	Blood in Schlemms Canal	Other	None
Other findings on gonioscopy -Left Eye	◯	◯	◯	◯	◯

Other

_____

Diagnosis - Right Eye

Diagnosis - Left Eye

Visuial Field

Target - Right Eye ◯ Seen ◯ Not Seen

What was used? - Right Eye ◯ CVF 24-2 ◯ CVF 10-2

Stimulus - Right Eye ◯ III ◯ V

MD - Right Eye

PSD - Right Eye

	Outside normal limits	Within normal limits	Borderline	Generalized depression of sensitivities	Abnormally high sensitivity
GHT - Right Eye	◯	◯	◯	◯	◯

Target - Left Eye ◯ Seen ◯ Not Seen

What was used? - Left Eye ◯ CVF 24-2 ◯ CVF 10-2

Stimulus - Left Eye ◯ III ◯ V

MD - Left Eye

PSD - Left Eye

	Outside normal limits	Within normal limits	Borderline	Generalized depression of sensitivities	Abnormally high sensitivity
GHT - Left Eye	◯	◯	◯	◯	◯

Type of treatment - Right Eye ◯ Medical ◯ Surgical ◯ Both ◯ No Treatment

List drugs

What type of surgery was done?

When was it done?

_____

Type of treatment - Left Eye

◯ Medical ◯ Surgical
◯ Both ◯ No Treatment

List drugs

What type of surgery was done?

_____

When was it done?

_____

Samples collected

◯ Yes ◯ No

Keratometric Reading

	Possible	Not Possible
Right Eye	◯	◯
Left Eye	◯	◯

Keratometric 1 - Right Eye

_____

Keratometric 1 - Left Eye

_____

Keratometric 2 - Right Eye

_____

Keratometric 2 - Left Eye

_____

Axial length - Right Eye

_____
(mm)

Axial length - Left Eye

_____
(mm)

Anterior Chamber Depth - Right Eye

_____

Anterior Chamber Depth - Left Eye

_____

Lens Diameter - Right Eye

_____

Lens Diameter - Left Eye

_____

Central Corneal Thickness - Right Eye

_____

Central Corneal Thickness - Left Eye

_____

OCT

	Possible	Not Possible
Right Eye	◯	◯
Left Eye	◯	◯

Horizontal CDR on OCT - Right Eye

_____

Vertical CDR on OCT - Right Eye

_____

OCT Date - Right Eye

_____

Horizontal CDR on OCT - Left Eye

_____

Vertical CDR on OCT - Left Eye

_____

OCT Date - Left Eye

_____

Superior RNFL - Right Eye

_____

Superior RNFL - Right Eye

◯ Within normal limit
◯ Borderline
◯ Outside normal limit

Superior RNFL - Left Eye

_____

Superior RNFL - Left Eye

◯ Within normal limit
◯ Borderline
◯ Outside normal limit

Inferior RNFL - Right Eye

_____

Inferior RNFL - Right Eye

◯ Within normal limit
◯ Borderline
◯ Outside normal limit

Inferior RNFL - Left Eye	_____
Inferior RNFL - Left Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Nasal RNFL - Right Eye	_____
Nasal RNFL - Right Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Nasal RNFL - Left Eye	_____
Nasal RNFL - Left Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Temporal RNFL - Right Eye	_____
Temporal RNFL - Right Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Temporal RNFL - Left Eye	_____
Temporal RNFL - Left Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Mean RNFL - Right Eye	_____ (micrometers)
Mean RNFL - Right Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Mean RNFL - Left Eye	_____ (micrometers)
Mean RNFL - Left Eye	◯ Within normal limit ◯ Borderline ◯ Outside normal limit
Disc Diameter - Right Eye	_____
Disc Diameter - Left Eye	_____

Rim Symmetry - Right Eye

Rim Symmetry - Left Eye

Rim Area - Right Eye

Rim Area - Left Eye

Disc Area - Right Eye

Disc Area - Left Eye

Cup Volume - Right Eye

Cup Volume - Left Eye

ONH Analysis - Right Eye

ONH Analysis - Left Eye

Area CD - Right Eye

Area CD - Left Eye

Vertical CD - Right Eye

Vertical CD - Left Eye

Horizontal CD - Right Eye

Horizontal CD - Left Eye

GCC Parameters

FLV - Right Eye

FLV - Left Eye

GLV - Right Eye	_____
GLV - Left Eye	_____
OCT - Right Eye	
Scan quality index - Right Eye	_____
OCT - Left Eye	
Scan quality index - Left Eye	_____
CVF - Right Eye	
Scan quality index - Right Eye	_____
CVF - Left Eye	
Scan quality index - Left Eye	_____
Would you wish to be contacted with the results of this study?	◯ Yes ◯ No