

OHTS 20-year Follow-up Test and Measures: FV

Patient ID:

Visit Date: / /
mm dd yy

Check Completed	Modules	Pg
<input type="checkbox"/>	Informed Consent	
<input type="checkbox"/>	OHTS Symptom checklist (SY)	
<input type="checkbox"/>	Quality of Life (NEI-VFQ, SF-36 and FM)	
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<input type="checkbox"/>	ETDRS	10
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Comments:

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MODULE: Current Medications

Current Medication

1. **Is the patient currently taking any of the following categories of medication?**

(Consult PDR if needed)

- | | | |
|---|------------------------------|-----------------------------|
| a. Systemic Beta-blocker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Calcium Channel Blocker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Statin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Anti-Depressant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Ocular Corticosteroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Systemic Corticosteroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Nasal Steroid..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Bronchial Inhaled Steroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Estrogen or Progesterone for hormone replacement therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Ace Inhibitors | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Lubricating eye drops, ointments or gels.... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Current Medication Comments:

Certification (CC or PI)

Examples:
Systemic beta blockers: acebutolol (Sectral), atenolol (Tenormin), bisoprolol (Zebeta), metoprolol (Lopressor, Lopressor LA, Toprol XL), nadolol (Corgard), labetalol hydrochloride (Trandate, Normodyne), timolol maleate (Blocadren) and propranolol (Inderal).
Calcium channel blockers: Norvasc (amlodipine), Plendil (felodipine), DynaCirc (isradipine), Cardene (nicardipine), Procardia XL, Adalat (nifedipine), Cardizem, Dilacor, Tiazac, Diltia XL (diltiazem), Sular (Nisoldipine), Isoptin, Calan, Verelan, Covera-HS (verapamil).
Statins: atorvastatin (Lipitor), fluvastatin (Lescol), lovastatin (Mevacor, Altacor), pravastatin (Pravachol), rosuvastatin (Crestor), simvastatin (Zocor), and pitavastatin (Livalo).
Anti-depressants: Mirtazapine (Remeron), Escitalopram (Lexapro), Venlafaxine (Effexor), Sertraline (Zoloft), Citalopram (Celexa), Bupropion (Wellbutrin), Paroxetine (Paxil), Milnacipran (Savella), Fluoxetine (Prozac), Duloxetine (Cymbalta), Fluvoxamine (Luvox), Reboxetine (Vestra).
Ocular Steroids: Rimexolone ophthalmic (Vexol), Dexamethasone ophthalmic (Decadron Maxidex), Difluprednate ophthalmic (Durezol), Fluorometholone ophthalmic (Flarex, Fluor-Op, FML, FML Liquifilm, FML Forte), Loteprednol etabonate ophthalmic (Alrex, Lotemax), and Prednisolone acetate ophthalmic (Omnipred, Pred Forte, Pred Mild).
Systemic steroids: prednisone (Prednisone Intensol), dexamethasone (Dexamethasone Intensol, DexPak), hydrocortisone (Cortef), triamcinolone (Aristospan Intra-Articular, Aristospan Intralesional), and Methylprednisone (Medrol).
Nasal steroids: flunisolide nasal spray (Nasarel), budesonide nasal spray (Rhionocort), fluticasone propionate nasal spray (Flonase), mometasone nasal spray (Nasonex), and triamcinolone nasal spray (Nasacort AQ).
Inhaled steroids: Aerespan, Alvesco, Asmanex, Flovent, Pulicort and Qvar.
Estrogen and Progesterone hormone therapy: Estradiol, Divigel, Elestrin, Esclim, Estrace, Estraderm, Estrasorb, Estring, Estrogel, Evamist, Alora, Prometrium, Provera, Activella, Angeliq, Climara Pro, Prefest, and Prempro.
Ace Inhibitors: benazepril (Lotensin), captopril (Capoten), enalapril (Vasotec, Epaned), fosinopril (Monopril), lisinopril (Prinivil, Zestril), moexipril (Univasc), perindopril (Aceon), quinapril (Accupril), ramipril (Altace), and trandolapril (Mavik).

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MODULE: Diabetes History

Diabetes History

1. Has a doctor or health professional ever told you that you had a high sugar level or sugar diabetes?

Check only one:

- Yes
- No
- Yes, borderline diabetes
- Yes, only during pregnancy
- Unknown

Which physician or clinic made the diagnosis?

Examples of diabetic pills:

- Metformin (Glucophage, Fortamet)
- Glipizide and Metformin (Glucovance)
- Pioglitazone (Actos)
- Sitagliptin (Januvia)
- Saxagliptin (Onglyza)
- Linagliptin (Tradjenta)
- Acarbose (Precose)
- Miglitol (Glyset)
- Glipizide (Glucotrol XL)
- Glyburide (Micronase)
- Glimepiride (Amaryl)
- Repaglinide (Prandin)
- Nateglinide (Starlix)
- Colesevelam (Welchol)
- Pioglitazone & metformin (Actoplus Met)
- Glipizide & metformin (Metaglip)
- Sitagliptin & metformin (Janumet)
- Saxagliptin & metformin (kombiglyze)

2. Are you currently taking insulin?

Check only one:

- Yes
- No
- Unknown

3. Are you currently taking diabetic pills to lower your blood sugar?

These are sometimes called oral agents or oral hypoglycemic agents.

Check only one:

- Yes
- No
- Unknown

3a. If currently taking diabetic pills to lower your blood sugar, is the pill Metformin or Glucophage?

Check only one:

- Yes
- No
- Unknown

4. Has a doctor or health professional ever recommended a special diet to lower your blood sugar?

Check only one:

- Yes
- No
- Unknown

Certification (CC or PI):

Diabetes History Comments:

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mm dd yy

MODULE: Ocular Treatment

Ocular Treatment

1. Have you had treatment for eye disease or have you had eye surgery? Yes No

2. If yes, check appropriate boxes:

- | | OD | OS |
|---|------------------------------|------------------------------|
| a. Cataract surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| b. YAG capsulotomy | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| c. Treatment for Macular Degeneration | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| (vitamins, laser, injections) | | |
| d. Treatment for diabetic retinopathy..... | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| (laser, injections) | | |
| e. Laser trabeculoplasty/SLT | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| f. Laser iridotomy..... | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| g. Filtering surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| h. Seton surgery (tube shunt)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| i. Combined cataract/filtering surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| j. Penetrating keratoplasty/DSEK/DMEK | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| k. Retinal detachment repair | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| l. Retinal tear..... | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| m. Refractive surgery (e.g. LASIK)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| n. Lid surgery (Describe in comment) | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| o. Treatment for dry eyes, Blepharitis, or Trichiasis.. | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| p. Other (describe): | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |

Certification (CC or PI):

Ocular Treatment Comments:

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mm dd yy

MODULE: Ocular Hypotensive Medications

Ocular Hypotensive Medications

3. Have you taken eyedrops to lower the pressure in your eyes after your last OHTS visit..... Yes No

3a. If yes, estimate the number of months you took eyedrops to lower pressure since your last OHTS visit.

4. Are you currently using eyedrops to lower the pressure in your eyes? Yes No

If yes, which ocular medications (eyedrops) are you currently taking to lower the pressure in your eyes?

OD OS

- 4a. Prostaglandin Analogue Yes Yes
- 4b. Beta-Blockers Yes Yes
- 4c. Alpha 2 Agonist Yes Yes
- 4d. Topical Carbonic Anhydrase Inhibitor Yes Yes
- 4e. Miotics Yes Yes
- 4f. Epinephrine/Dipivefrin Yes Yes
- 4g. Combination Medications Yes Yes
- 4h. Other..... Yes Yes

Describe Other Ocular Hypotensive Medication _____

OH Meds Comments:

Certification (CC or PI)

Examples:

Prostaglandin Analogues: latanaprost(Xalatan), bimatoprost(Lumigan), travoprost(Travatan.), and tafluprost (Zioptan).

Beta-blockers: betaxolol (Betoptic), carteolol (Ocupress), levobunolol (AK-Beta, Betagan), metipranolol (OptiPranolol), and timolol (Betimol, Istalol, Timoptic).

Alpha 2-Agonist : apraclonidine (Iopidine), brimonidine (Alphagan).

TCAI: Dorzolamide (Trusopt), Brinzolamide (Azopt)

Miotics: Pilocarpine (Isopto Carpine), Carbachol (Isopto Carbachol), Pilocarpine HCL Gel (Pilopine HS Gel).

Epinephrine/Dipivefrin : Propine

Combination medications: Combigan (Brimonidine Tartrate & Timolol Maleate) , Cosopt (Dorzolomide HCl & Timolol Maleate), and Simbrinza (Brinzolamide/Brimonidine tartrate ophthalmic suspension).

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MODULE: Medical History

Medical History

1. What is your current height? Feet Inches
2. What is your current weight? Pounds
3. Are you a current smoker (include cigarettes, cigars, pipe and chewing tobacco)?..... Yes No
4. Are you a former smoker (include cigarettes, cigars, pipe and chewing tobacco)?..... Yes No
5. If a current or former smoker (include cigarettes, cigars, pipe and chewing tobacco), how many years did you smoke?..... Years
6. If a current or former cigarette smoker, how many packs per day did you smoke? Packs/Day
7. Have you had an inpatient hospitalization since (state last OHTS visit)? Yes No
If yes, describe _____
8. Have you had any surgery other than ocular surgery since (state last OHTS visit)? Yes No
If yes, describe _____
9. Ask: “Do any of the following blood relatives have glaucoma?”

	Yes	No	Unknown
a. Biological Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Biological Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Biological Brother or Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Biological Aunt or Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Biological Grandmother or Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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mm dd yy

MODULE: Medical History

Medical History

10. Has a doctor ever told you that you have any of the following conditions?

- 1. Cardiovascular disease..... Yes No Unknown
- 2. High blood pressure (hypertension) Yes No Unknown
- 3. Low blood pressure (hypotension) Yes No Unknown
- 4. Coronary artery disease Yes No Unknown
- 5. Congestive heart failure Yes No Unknown
- 6. Implantable heart devices Yes No Unknown
- 7. Irregular heartbeat..... Yes No Unknown
- 8. Rheumatic fever Yes No Unknown
- 9. High Cholesterol/lipids Yes No Unknown
- 10. Heart attack..... Yes No Unknown
- 11. Stroke Yes No Unknown
- 12. Seizures Yes No Unknown
- 13. Chronic lung disease Yes No Unknown
- 14. Asthma Yes No Unknown
- 15. C.O.P.D. Yes No Unknown
- 16. Tuberculosis..... Yes No Unknown
- 17. Cancer Yes No Unknown
- 18. Migraine headaches Yes No Unknown
- 19. Depression, Anxiety, or other mental health problems Yes No Unknown
- 20. Thyroid disease..... Yes No Unknown
- 21. Anemia..... Yes No Unknown
- 22. Liver disease including Hepatitis..... Yes No Unknown
- 23. Kidney disease Yes No Unknown
- 24. Reflux (G.E.R.D.) Yes No Unknown
- 25. Genitourinary problems Yes No Unknown
- 26. Arthritis..... Yes No Unknown
- 27. Sleep Apnea..... Yes No Unknown
- 28. Parkinson disease..... Yes No Unknown
- 29. Dementia/Alzheimer's Yes No Unknown
- 30. Raynaud's Disease Yes No Unknown
- 31. Other conditions: Yes No Unknown

Medical History Comments:

History reviewed by:

Investigator Certification:

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mm dd yy

MODULE: Blood Pressure

Blood Pressure

1. 1st Blood Pressure

Systolic/Diastolic: SYS /DIA Pulse

2. Reason for not having Blood Pressure or Pulse Data (check all that apply):

- a. Monitor inoperative Yes
- b. Cuff too small Yes
- c. Blood pressure greater than 280 mmHg Yes
- d. Pulse too low Yes
- e. Pulse too high Yes
- f. Movement Yes
- g. Other conditions Yes

3. 2nd Blood Pressure

Systolic/Diastolic: SYS /DIA Pulse

4. Reason for not having Blood Pressure or Pulse Data (check all that apply):

- a. Monitor inoperative Yes
- b. Cuff too small Yes
- c. Blood pressure greater than 280 mmHg Yes
- d. Pulse too low Yes
- e. Pulse too high Yes
- f. Movement Yes
- g. Other conditions Yes

Blood Pressure taken by:

Blood Pressure Comments:

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mm dd yy

MODULE: Refraction

Refraction

1. Refraction OD Plus Minus . Plus Minus . x

2. Refraction OS Plus Minus . Plus Minus . x

Refraction taken by:

Refraction Comments:

MODULE: Snellen V.A.

Snellen V.A.

1. Snellen visual acuity OD / CF HM LP NLP

2. Snellen visual acuity OS / CF HM LP NLP

Or choose

Snellen acuity taken by:

Snellen VA Comments:

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mm dd yy

MODULE: ETDRS

ETDRS Best Corrected Visual Acuity

ETDRS visual acuity - OD

1. Testing distance in meters (checkbox) 4.0m 3.2m 2.5m 2.0m

2. Total number correct: OD

ETDRS visual acuity - OS

3. Testing distance in meters (checkbox) 4.0m 3.2m 2.5m 2.0m

4. Total number correct: OS

ETDRS Comments:

ETDRS acuity taken by:

MODULE: Pelli-Robson CS

Pelli-Robson CS

Pelli-Robson - OD

1. Score from OD .

Pelli-Robson - OS

2. Score from OS .

Pelli-Robson Comments:

Pelli-Robson taken by:

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IOP is measured by two people
- the OPERATOR aligns the mires
- the RECORDER reads the dial

MODULE: IOP

IOP

1. **Date IOP completed** / /
mm dd yy
2. **Time of day** Military Time
3. **1st IOP** mm Hg **OD** mm Hg **OS**
4. **2nd IOP** mm Hg mm Hg
- Are the 1st and 2nd IOP determinations less than or equal to 2 mm Hg apart?**
Yes: Enter their average on line 6. **No:** Take a 3rd reading and enter on line 5.
5. **3rd IOP** mm Hg mm Hg
➤ If a 3rd IOP is taken, enter the median (middle value) of 1st, 2nd, and 3rd IOP on line 6.
6. **IOP Result** mm Hg mm Hg
➤ Round to nearest whole number
➤ Round up when decimal is .5 or greater
7. **Check here if using a Non-Goldmann Tonometer**

If Non-Goldmann Tonometer, name of other instrument: _____

Operator Certification

Recorder Certification

IOP Comments:

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MODULE: Ocular Examination

Ocular Examination

1. **Date ocular exam completed** / /
mm dd yy
 2. **External examination:**
OD Normal Abnormal, describe: _____
OS Normal Abnormal, describe: _____
 3. **Slit lamp examination:**
OD Normal Abnormal, describe: _____
OS Normal Abnormal, describe: _____
 4. **Presence of pseudoexfoliation (Not required for repeat visits)**
 5. **Direct ophthalmoscopic examination:**
OD Normal Abnormal (other than disc hemorrhage), describe: _____
OS Normal Abnormal (other than disc hemorrhage), describe: _____
 6. **If disc hemorrhage: (check here)**
OD Yes (list clock hours): : to :
OS Yes (list clock hours): : to :
 - 7) **Investigator answers the following question:**
Has patient developed any condition(s), other than glaucoma, that can cause visual field loss and/or disc damage (branch vein occlusion, ischemic optic neuropathy, macular degeneration, pituitary lesion, demyelinating disease, pseudotumor, etc.)?
OD Yes No
OS Yes No
- 7a. If yes, describe by eye cause of visual field loss and/or disc damage (other than glaucoma).
- _____
- _____

Ocular Exam Comments:

Investigator Certification:

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MODULE: Gonioscopy

Gonioscopy

1. Gonioscopy:

OD

- Open angles
- Narrow angles (Angle slit or Grade 1 in more than 25% of the circumference)
- Appositional (Angle closure over more than 25% of the circumference)
- Closure (PAS over more than 25% of the circumference)

OS

- Open angles
- Narrow angles (Angle slit or Grade 1 in more than 25% of the circumference)
- Appositional (Angle closure over more than 25% of the circumference)
- Closure (PAS over more than 25% of the circumference)

Gonioscopy Comments:

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MODULE: Humphrey VF

Humphrey SITA 30-2 VF Series

- Use OHTS certified perimeter only.
- Send Visual Fields to VFRC within 14 days.
- If 1st field is unreliable, and retesting will yield better data, repeat the field in 1 hour or schedule a 2nd or 3rd visit as required by the protocol.

1. For which eye(s) were Visual Fields taken for this patient? OU OD OS Neither
2. If taken, enter dates **OD** / / **OS** / /
- mm dd yy mm dd yy
3. If additional VFs taken, enter dates **OD** / / **OS** / /
- mm dd yy mm dd yy
- If patient has already been diagnosed with a VF POAG in OHTS, has an additional protocol-required visit, to complete a 2nd/3rd VF(s), been scheduled? Yes No
4. If one or both eyes **were not tested or unreliable**, does PI think retesting will provide better data? Yes, retest **OD**
 No, retesting OD will not yield better data (Explain below)
 Yes, retest **OS**
 No, retesting OS will not yield better data (Explain below)

If patient has unreliable/abnormal VF(s) (criteria for abnormality = p<5% for the PSD or if the GHT is outside normal limits) the VFRC may require a 2nd/3rd VF(s).

5. If PI determines VF(s) recorded were unreliable or abnormal, were additional VF(s) done this visit? Yes No
6. Is there an additional visit scheduled for 2nd/3rd VF(s)? Yes No

VF Technician Certification:

Visual Field Comments:

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MODULE: Disc Photography

Disc Photography

➤ Send photos to OHTS Coordinating Center within 14 days.
➤ Take 2 sets of "Best Quality" stereo photographs per eye.

1. For which eye(s) were Optic Disc Photos taken for this patient? OU OD OS Neither

2. Enter date of 1st set of stereo photographs

	OD		OS	
<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>
mm		dd		yy

3. Enter date of 2nd set of stereo photographs

	OD		OS	
<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>
mm		dd		yy

4. If one or both eyes were not photographed or ungradeable, does PI or photographer think retesting will provide better data?

Yes, retest **OD**
 No, retesting OD will not yield better data (Explain below)

Yes, retest **OS**
 No, retesting OS will not yield better data (Explain below)

Photographer Certification:

Disc Photography Comments:

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MODULE: OCT

Optical Coherence Tomography

- Send OHTS 3 OCT and previous OCT images to OHTS Coordinating Center during your clinic's monthly window.
- For Spectralis, complete 2 RNFL Circle scans and 2 P.Pole scans per eye.
- For Cirrus, complete 2 Optic Disc Cube (200x200) and 2 Macular Cube (512x128) per eye.

1. For which eye(s) were OCT taken for this patient? OU OD OS Neither

2. If taken, enter dates

		/			/				
mm			dd			yy		mm	

OD **OS**

3. Instrument used for OCT scan? Spectralis Cirrus

4. If scans were not done or were poor quality please explain reason below.

OCT Technician Certification:

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OCT Comments:

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