OHTS Functional Measures: FM

Patient ID: ☐☐ ☐☐☐☐☐

Visit Date: ☐☐ / ☐☐ / ☐☐
mm dd yy

Was the FM form completed by telephone survey? ☐ Yes ☐ No

Coordinators Certification if FM form completed by telephone survey. ☐☐☐

MODULE: Falls Survey

1.

DURING THE PAST 12 MONTHS, how fearful were you of falling? (Circle only one answer)	Don't Know	A Little Fearful	Moderately Fearful	Very Fearful	I was not Fearful

2.

DURING THE PAST 12 MONTHS, how many times have you fallen? (Circle only one answer)	Don't Know	0	1	2 or 3	4 or 5	6 or more

2a. IF YOU FELL IN THE PAST 12 MONTHS, which of the following injuries did you have?
(Check all that apply)

- ☐ No injury
- ☐ I had a bruise or bleeding
- ☐ I had a sprain or a strain
- ☐ I hit or injured my head
- ☐ I broke or fractured a bone
- ☐ I had some other kind of injury. Please describe: _____

_____

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Instructions to Patient:

Please circle the correct answer on the scale ranging from 1 to 5 where (1) stands for no difficulty, (2) for a little bit of difficulty, (3) for some difficulty, (4) for quite a lot of difficulty, and (5) for severe difficulty. If you do not perform any of the activities for other than visual reasons, please circle (0).

MODULE: Glaucoma Quality of Life Survey

Circle one number on each line	No Difficulty at All	A Little Difficulty	Some Difficulty	Quite a Lot	Severe Difficulty	Do Not Perform for Non Visual Reasons
3. Reading newspapers or fine print	1	2	3	4	5	0
4. Walking after dark	1	2	3	4	5	0
5. Seeing at night	1	2	3	4	5	0
6. Walking on uneven ground	1	2	3	4	5	0
7. Adjusting to bright lights	1	2	3	4	5	0
8. Adjusting to dim lights	1	2	3	4	5	0
9. Going from light to dark room or vice versa	1	2	3	4	5	0
10. Tripping over objects	1	2	3	4	5	0
11. Seeing objects coming from the side	1	2	3	4	5	0
12. Crossing the road	1	2	3	4	5	0
13. Walking on steps/stairs	1	2	3	4	5	0
14. Bumping into objects	1	2	3	4	5	0
15. Judging distance of foot to step/curb	1	2	3	4	5	0
16. Finding dropped objects	1	2	3	4	5	0
17. Recognizing faces	1	2	3	4	5	0

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Note to Patient: Your answers from this form will be kept confidential and will not be shown to your OHTS clinician or shared with your state's Division of Motor Vehicles.

MODULE: Driving Questionnaire

18. Are you currently driving, at least once in a while? ☐ Yes ☐ No

If No 

. Skip questions 19-27 on this page. The form is now complete.

19. How fast do you usually drive compared to the general flow of traffic?

- ☐ Much faster
- ☐ Somewhat faster
- ☐ About the same
- ☐ Somewhat slower
- ☐ Much slower

20. Has anyone suggested over the past year that you limit your driving or stop driving?
☐ Yes ☐ No

Circle one number on each line to describe the following activities during the past 3 months	No Difficulty at All	A Little Difficulty	Some Difficulty	Quite a Lot	Severe Difficulty	Do Not Perform for Non Visual Reasons
21. Driving when raining	1	2	3	4	5	0
22. Driving when alone	1	2	3	4	5	0
23. Parallel parking	1	2	3	4	5	0

24. How many car accidents have you been involved in over the past year when you were the driver? Please tell me the number of all car accidents, whether or not you were at fault.
_____ accidents.

25. When driving over the past year, have you been involved in an accident where your car hit a stationary object? ☐ Yes ☐ No

26. Have you been injured in a car accident during the past year? ☐ Yes ☐ No

27. How many miles do you drive a year? _____ miles a year.