OHTS Functional Measures: FM

idnum Patient ID: ☐☐ ☐☐☐☐☐

fm_examdate Visit Date: ☐☐ / ☐☐ / ☐☐
mm dd yy

1 2

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

phone_fm

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

coord_fm

MODULE: Falls Survey

	fs_fearful	1	2	3	4	5
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

	fs_fallen	1	2	3	4	5	6
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) 1 if checked, 2 if blank

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

_____

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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	1 No Difficulty at All	2 A Little Difficulty	3 Some Difficulty	4 Quite a Lot	5 Severe Difficulty	0 Do Not Perform for Non Visual Reasons
gq_news	3. Reading newspapers or fine print	1	2	3	4	5	0
gq_dark	4. Walking after dark	1	2	3	4	5	0
gq_night	5. Seeing at night	1	2	3	4	5	0
gq_uneven	6. Walking on uneven ground	1	2	3	4	5	0
gq_bright	7. Adjusting to bright lights	1	2	3	4	5	0
gq_dim	8. Adjusting to dim lights	1	2	3	4	5	0
gq_lt2dk	9. Going from light to dark room or vice versa	1	2	3	4	5	0
gq_trip	10. Tripping over objects	1	2	3	4	5	0
gq_side	11. Seeing objects coming from the side	1	2	3	4	5	0
gq_road	12. Crossing the road	1	2	3	4	5	0
gq_stairs	13. Walking on steps/stairs	1	2	3	4	5	0
gq_bumpobj	14. Bumping into objects	1	2	3	4	5	0
gq_curb	15. Judging distance of foot to step/curb	1	2	3	4	5	0
gq_dropobj	16. Finding dropped objects	1	2	3	4	5	0
gq_faces	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? ☐ 1 Yes ☐ 2 No

fmdriving If No STOP. 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?

dq_fast
- ☐ Much faster 1
- ☐ Somewhat faster 2
- ☐ About the same 3
- ☐ Somewhat slower 4
- ☐ Much slower 5

20. Has anyone suggested over the past year that you limit your driving or stop driving?

dq_limit ☐ 1 Yes ☐ 2 No

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

25. When driving over the past year, have you been involved in an accident where your car hit a stationary object? fm_stationary ☐ 1 Yes ☐ 2 No

26. Have you been injured in a car accident during the past year? ☐ 1 Yes ☐ 2 No
fmdriving_1

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