

**Telephone Medical History: Participants Unable/Unwilling to Return for OHTS Examination**

OHTS clinic enters Patient ID:

Date of telephone interview:  /  /

**Module: Ocular Status**

1. Has a doctor told you that you have glaucoma?..... Yes  No  Uncertain

2. Have you been diagnosed with any of the following eye conditions?

- a) A stroke in the eye ..... Yes  No  Uncertain
- b) A blood clot in the eye..... Yes  No  Uncertain
- c) Macular degeneration ..... Yes  No  Uncertain
- d) Cataract ..... Yes  No  Uncertain
- e) Diabetes in the eye ..... Yes  No  Uncertain
- f) Stroke that affects vision..... Yes  No  Uncertain
- g) Other ..... Yes  No  Uncertain

Describe other eye conditions: \_\_\_\_\_

3. Is there an IOP measurement recorded in your ocular history?  Yes  No

3a. If yes, enter date of most recent IOP:  /  /   
mm dd yy

*If multiple IOP measurements were done on the same day, please average*

3b. Most recent IOP **OD**:  Most recent IOP **OS**:

Ocular Status Comments:

Interviewer Certification:

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**MODULE: Current Medications**

1. Are you currently taking any medications?  Yes  No

Medication	Total Daily Dose (Freq. Per Day)	Indication or Reason For Use
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

2. Are you taking any of the following types of medicine (see list on next page)

- a. Systemic Beta-blocker.....  Yes  No  Uncertain
- b. Calcium Channel Blocker.....  Yes  No  Uncertain
- c. Statin.....  Yes  No  Uncertain
- d. Anti-Depressant.....  Yes  No  Uncertain
- e. Ocular Corticosteroid.....  Yes  No  Uncertain
- f. Systemic Corticosteroid.....  Yes  No  Uncertain
- g. Nasal Steroid.....  Yes  No  Uncertain
- h. Bronchial Inhaled Steroid.....  Yes  No  Uncertain
- i. Estrogen or Progesterone for hormone replacement therapy.....  Yes  No  Uncertain
- j. ACE Inhibitors.....  Yes  No  Uncertain
- k. Lubricating eye drops, ointments or gels.....  Yes  No  Uncertain

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**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, Promentrium, 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), andtrandolapril (Mavik).

Current Medications Comments:

Interviewer Certification: 

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**MODULE: Ocular Treatment****1. Have you ever had any of these eye treatments or surgeries, if yes, which eye(s)?**

- |   | <b>Right Eye</b>   | <b>Left Eye</b>  |
|---|--|--|
| a. Cataract surgery .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| b. Laser treatment for film after cataract surgery.....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| c. Treatment for Macular Degeneration.....<br>(vitamins, laser, injections) | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| d. Treatment for diabetic retinopathy<br>(laser, injections) .....          | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| e. Laser treatment for glaucoma.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| f. Laser iridotomy for narrow angles.....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| g. Filtering surgery, trabeculectomy .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| h. Seton surgery (tube shunt) .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| i. Combined cataract/filtering surgery .....                                | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| j. Corneal transplant .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| k. Retinal detachment repair .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| l. Retinal tear or hole .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| m. Refractive surgery (e.g. LASIK).....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| n. Lid surgery (describe in comment) .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| o. Other.....   | <input type="checkbox"/> Yes   | <input type="checkbox"/> Yes   |

Describe other eye treatments or surgeries: \_\_\_\_\_

Ocular Treatment Comments:

Interviewer Certification:

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**MODULE: Ocular Hypotensive Medications**

1. Are you currently using any eyedrops to lower your intraocular pressure?  Yes  No

**Right Eye** **Left Eye**

- |   |  |  |
|---|--|--|
| a. Prostaglandin Analogue (Light blue or turquoise) ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| b. Beta-Blockers (yellow or blue) .....                   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| c. Alpha 2 Agonist (purple) .....                         | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| d. Topical Carbonic Anhydrase Inhibitor (orange) .....    | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| e. Miotics (green) .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| f. Epinephrine/Dipivefrin .....                           | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| g. Combination Medications .....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |
| h. Other .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |

Describe other eyedrops: \_\_\_\_\_

Ocular Hypotensive Medications Comments:

**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

1. Have you ever been diagnosed with any of the following conditions?

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

Describe other conditions: \_\_\_\_\_

Medical History Comments:

Interviewer Certification: [ ][ ]