GLAUCOMA  
A. Patient Study #:____________  B. Date:__________  C. Interviewer:__________

**INCLUSION CRITERIA**

- Glaucoma treatment at Stanford Hospital and Clinics for at least 12 months
- D. Dx of Primary Glaucoma (but not AMD or DR)
- POAG(1)  PACG(Narrow Angle)(2)  NTG/LTG (Normal/Low tension glaucoma)(3)
- PXFG(Pseudexfoliation glaucoma)(4)  PG(Pigmentary Glaucoma)(5)  Inflammatory Glaucoma (6)
- Age >= 18 years

**E. DOB______  F.Age______  G.Sex □ M(1) □ F(2)**

Corrected Visual Acuity: H.OD:________  I. OS:________

Uncorrected Visual Acuity: J. OD:_______  K. OS:_______

**L. OD:______________  M. OS:______________**

**N. Past EYE Surgeries □ Yes(2) □ No(0)**

O. (Specify ______________)

**P. Past Glaucoma Procedures □ Yes(2) □ No(0)**

Q. Specify: HVF/GVF (1) Laser(2) Injections(3) Other(4)

**R. Past Glaucoma Surgeries □ Yes(2) □ No(0)**

S. (Specify ______________ )

**X. Diabetes Diagnosis: □ Yes (2) □ No (0)**

**Y. In the past 12 months, have you seen an ophthalmologist outside of Stanford for your glaucoma? □ Yes (2) □ No (0)**

**Z. If YES, how many glaucoma exams? ___________ (If answer to above question is NO, put zero)**

**AA. How long have you had glaucoma? __________________**

**AB. How were you diagnosed with glaucoma?**

- □ Did the ophthalmologist tell you that you have glaucoma during a routine eye exam?(1)
- □ Or, did you have symptoms and then see an ophthalmologist?(2)

**AC. Do you have glaucoma: □ in one eye?(1) □ in both eyes?(2)**

**AD. Date first seen at Stanford for glaucoma: ________________**

**AF. Primary Language □ English(1) □ Spanish(2) □ Cantonese(3) □ Mandarin(4) □ Russian(5)**

- □ Vietnamese (6) □ Filipino(7) □ Hindi/Indian dialect(8) □ Other (9)

**AG. Race/Ethnicity □ White/Caucasian(1) □ Black/African-American(2)**

- □ Hispanic/Latino: (3) Please specify ________________
- □ Asian/Pacific Islander: (4) Please specify: ________________
- □ American Indian / Alaskan Native:(5) Please Specify ________________
- □ Indian(6) ________________

- □ Middle Eastern(7) ________________
- □ Other(8) ________________

**AH. What type of Housing do you live in?**

- □ Own/Rent(1) □ Assisted Living (5)
- □ Public Housing(2)
- □ Shelter/Group/Transitional Home(3)
- □ Homeless(4): □ AI. How long have you been homeless? __________

**AJ. Do you live with family/friends? □ Yes(2) □ No(0)**

**AK. Size of Household? ________________**
### Health Insurance

**AL.** Do you have health insurance?  
- Yes(2)  
- No(0)

**AM.** If Yes, what kind?  
- Medicare(1)  
- MediCal(2)  
- Private (3)  
- Self-pay / no insurance(4)  
- Other(5)  

### Employment

**AN.** Employment  
- Employed full-time(1): Occupation________  
- Employed part-time(2): Occupation________  
- Retired(3): Prev. Occupation __________  
- Disability(4): Prev. Occupation __________  
- Unemployed/Laid Off(5)  
- Housewife(6)

**AO.** Employment  
- Employed full-time(1): Occupation________  
- Employed part-time(2): Occupation________  
- Retired(3): Prev. Occupation __________  
- Disability(4): Prev. Occupation __________  
- Unemployed/Laid Off(5)  
- Housewife(6)

### Highest Level of Education

<table>
<thead>
<tr>
<th>Did not attend school(1)</th>
<th>Elementary School(Gr K-6) (2)</th>
<th>Jr High(Gr 7-9) (3)</th>
<th>High School (Gr 10-12) (4)</th>
<th>Some College(5)</th>
<th>College(6)</th>
<th>Graduate Degree(7)</th>
<th>Other Degree/Cert.(8)</th>
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</thead>
</table>

**AQ.** Number of years of schooling? __________

### Travel to Clinic

**AR.** What type of transportation do you use to come to the clinic and return home? Mark all that apply.  
- Bus(1)  
- Car / Taxi(2)  
- Walking(3)  
- Bicycle / Motorcycle(4)  
- Transportation Services (5)

**AS.** How long does it take you to travel to the clinic?  
- _______ minutes

**AT.** How inconvenient is the transportation from your home?  
- Convenient(0)  
- Not inconvenient(1)  
- Somewhat inconvenient(2)  
- Very inconvenient(3)

**AU.** Do you require an escort to help you come to the clinic?  
- No(0)  
- Yes(1)

**AV.** How difficult is it for you (and any escorts) to take time away from home or work to come for glaucoma follow-up visits?  
- Easy(0)  
- Not too difficult(1)  
- Somewhat difficult(2)  
- Very difficult(3)

**AW.** Given your age and physical condition, how physically difficult is it for you to come to the clinic?  
- Easy(0)  
- Not too difficult(1)  
- Somewhat difficult(2)  
- Very difficult(3)

**AX.** How safe do you feel when you are traveling to and from the clinic?  
- Safe (0)  
- Neutral(1)  
- Unsafe(2)

### Costs of Glaucoma Medications and Follow-up Visits

**AY.** Do you take eye drops for your glaucoma?  
- Yes(2)  
- No(0)

**AZ.** If YES: “Patients with glaucoma sometimes have difficulty taking eye drops the way the doctor prescribed. In the last 14 days, how many days have you missed taking at least one dose of your medications?”  
- # days: __________  
- Often (≥ 5 days)(3)  
- Sometimes (3-4 days)(2)  
- Rarely (1-2 days)(1)  
- Never (0 days)(0)  
- N/A(6)

**BA.** If NO, why?  
- Not advised(2)  
- Other (1) (specify) __________  
- N/A(6)

**BB.** If YES: How much do you pay for your glaucoma eye drops every month?  
- _______  
- N/A(6)

**BC.** If YES: How difficult for you are the costs of your glaucoma eye drops?  
- N/A(6)
(For Interviewer to Complete)

Sources of Information About Glaucoma

Please list your sources of knowledge/information regarding glaucoma:

BD. Ophthalmologist & staff at clinic □ Yes(2) □ No(0)

BE. Pamphlets/Posters □ Yes(2) □ No(0)

BF. Family/relatives/friends □ Yes(2) □ No(0)

BG. Media (TV/Radio/Internet) □ Yes(2) □ No(0)

BH. Primary Care Physician □ Yes(2) □ No(0)

BI. Other __________________

Disease Knowledge Questions

BJ. Is glaucoma related to high pressure in the eye? □ Yes(2) □ No(0) □ Not sure(1)

BK. Is glaucoma related to damage to a nerve? □ Yes(2) □ No(0) □ Not sure(1)

BL. If untreated, can glaucoma cause severe or total vision loss? □ Yes(2) □ No(0) □ Not sure(1)

BM. Is vision loss from glaucoma permanent? □ Yes(2) □ No(0) □ Not sure(1)

BN. Does glaucoma usually require treatment and/or follow-up for life? □ Yes(2) □ No(0) □ Not sure(1)

Perceptions about Disease and Attending Follow-up

BO. How difficult is it for you to come for glaucoma follow-up visits every few months?

Easy(0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)

BP. How important do you feel it is to attend follow-up visits for glaucoma?

Not too Important(1) Somewhat Important(2) Very Important(3)

BQ. If you are taking your medications and you don’t see any changes in your vision, how important do you feel it is to attend your next follow-up visit as advised?

Not too Important(1) Somewhat Important(2) Very Important(3)

BR. In general would you say your glaucoma is:

Mild(1) Moderate(2) Severe(3)
Barriers to Eye Care Service Utilization
(If applicable) Which of the following have been significant barriers for you in attending your follow-up glaucoma exam visits in the past year? Mark all that apply.

BS. Long clinic waits
   □ Yes(2)   □ No(0)
   BT. Long waiting times at clinic
   □ Yes(2)   □ No(0)
   BU. If Yes, how long have you waited? ______________
   BV. Long (additional) wait times for interpreters
   □ Yes(2)   □ No(0)

BW. Rescheduling difficulties
   □ Yes(2)   □ No(0)
   BX. The office calls to cancel and reschedule my appointments
   □ Yes(2)   □ No(0)
   BY. I have trouble rescheduling my appointments
   □ Yes(2)   □ No(0)
   BZ. I could not reschedule an appointment more than 6 months in advance
   □ Yes(2)   □ No(0)

CA. I was unhappy with the care I received here in the past
   □ Yes(2)   □ No(0)
   CE. If Yes, please explain: ______________________________________________________________

CB. Financial Barriers:
   □ Yes(2)   □ No(0)
   CC. Clinic visit fees
   □ Yes(2)   □ No(0)
   CD. Transportation costs
   □ Yes(2)   □ No(0)
   CE. Lost wages
   □ Yes(2)   □ No(0)
   CF. Other (Specify)____________

CG. Unable to leave work responsibilities
   □ Yes(2)   □ No(0)

CH. Other medical or physical condition
   □ Yes(2)   □ No(0)
   CI. If Yes please specify________________________

CL. Lack of an escort
   □ Yes(2)   □ No(0)

CJ. Other serious personal issues to take care of
   □ Yes(2)   □ No(0)
   CK. If Yes, please specify____________________________

CL. Other incidental obligations
   □ Yes(2)   □ No(0)
   CM. If Yes, please specify __________________________

CN. Do you ever forget to come?
   □ Yes(2)   □ No(0)

CO. Do you ever miss an appointment because your eyes feel okay?
   □ Yes(2)   □ No(0)

CP. Do you ever miss an appointment because you don’t think it’s important to come for your regular glaucoma follow-up exams?
   □ Yes(2)   □ No(0)

CQ. Do you ever miss an appointment because you don’t feel safe when coming to clinic?
   □ Yes(2)   □ No(0)
(For Interviewer to Complete)

CR. Do you have any other reasons why it might be difficult for you to come for your scheduled appointments?_________________________

CS. What was the most important reason of those indicated above (mark question Letter)?__________☐N/A(6)

Potential Strategies to Facilitate Regular Glaucoma Follow-up

Which of the following would help you attend your regular glaucoma follow-up exams?

CT. Having a reminder a week before your scheduled date of visit (by phone, e-mail, text message, or letter) ☐ Yes(2) ☐ No(0)

CU. Having a mobile glaucoma van that comes to your area of residence once every few months on a specific day ☐ Yes(2) ☐ No(0)

CV. More education on the serious effects of glaucoma ☐ Yes(2) ☐ No(0)

CW. More education on why follow-up visits are important ☐ Yes(2) ☐ No(0)

CX. Parking vouchers ☐ Yes(2) ☐ No(0)

CY. Transportation service that brings you to clinic and takes you back home ☐ Yes(2) ☐ No(0)

CZ. Other strategies ________________________________________________________________________________________

Strategies to Improve Patient Support

DA. Do you know anyone else who suffers from glaucoma? ☐ Yes(2) ☐ No(0)

DB. If Yes, who? Family(1) Friend(2) Contact through a support network(3)

DC. Do you know anyone who has lost his/her vision later in life? ☐ Yes(2) ☐ No(0)

DD. If Yes, who? Family(1) Friend(2) Contact through a support network(3)

DE. Do you have a support network? ☐ Yes (2) ☐ No (0)

DF. If Yes, who? Family (1) Friend(2) Public Resource(3)

DG. Specify Resource:___

DH. Has the clinic provided you with resources or a support network to help you manage your eye condition? ☐ Yes(2) ☐ No(0)

DI. If yes, what are the resources? __________

DJ Do you feel like you would benefit from a support network of other people with glaucoma and/or an eye condition? ☐ Yes(2) ☐ No(0)
(For Interviewer to Complete)

<table>
<thead>
<tr>
<th>DIABETIC RETINOPATHY A. Patient Study #</th>
<th>B. Date:</th>
<th>C. Interviewer:</th>
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**INCLUSION CRITERIA**
- □ Diabetic retinopathy treatment at Stanford Hospital and Clinics for at least 12 months
- □ D. Dx of Diabetic Retinopathy (DR) (but not Glaucoma or AMD)
  - □ Nonproliferative (7)
  - □ Proliferative (8)
- □ Age >= 18 years

<table>
<thead>
<tr>
<th>E. DOB ________</th>
<th>F. Age: ________</th>
<th>G. Sex: □ M(1) □ F(2)</th>
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Corrected Visual Acuity: H. OD: ________  I. OS: ________
Uncorrected Visual Acuity: J. OD: ________  K. OS: ________

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<tr>
<th>N. Past EYE surgeries?</th>
<th>□ Yes(2) □ No(0)</th>
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<td>O. (Specify: _________)</td>
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<tr>
<th>P. Past DR Procedures</th>
<th>□ Yes (2) □ No(0)</th>
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<tr>
<td>Q. Specify: HVF/GVF (1) Laser(2) Injections(3) Other(4)</td>
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<tr>
<td>R. Past DR Surgeries</td>
<td>□ Yes(2) □ No(0)</td>
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<td>S. (Specify: _________)</td>
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<tr>
<th>T. Patient Cancellation/NOS without rescheduling in 1mo</th>
<th>□ Yes(2) □ No(0)</th>
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<th>U. #NOS in past 12 mo:</th>
<th>________</th>
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<th>V. #Patient Cancellations in past 12mo:</th>
<th>________</th>
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<th>W. Total #Scheduled appointments in past 12mo:</th>
<th>________</th>
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<tr>
<th>X. Diabetes Diagnosis:</th>
<th>□ Yes (2) □ No (0)</th>
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<th>Y. In the past 12 months, have you seen an ophthalmologist outside of Stanford for your diabetic retinopathy?</th>
<th>□ Yes (2) □ No (0)</th>
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<th>Z. If YES, how many diabetic retinopathy exams?</th>
<th>________ (if answer to above question is NO, put zero)</th>
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<th>AA. How long have you had diabetic retinopathy?</th>
<th>____________</th>
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<tr>
<th>AB. How were you diagnosed with diabetic retinopathy?</th>
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<td>□ Did the ophthalmologist tell you that you have DR during a routine eye exam? (1)</td>
<td></td>
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<tr>
<td>□ Or, did you have symptoms and then see an ophthalmologist? (2)</td>
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<tr>
<th>AC. Do you have DR:</th>
<th>□ in one eye? (1) □ in both eyes? (2)</th>
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<tr>
<th>AD. Date first seen at Stanford for diabetic retinopathy:</th>
<th>____________</th>
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<tr>
<th>AE. English Language Fluency</th>
<th>□ Yes(2) □ No(0)</th>
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<tr>
<th>AF. Primary Language</th>
<th>□ English(1) □ Spanish(2) □ Cantonese(3) □ Mandarin(4) □ Russian(5) □ Vietnamese(6) □ Filipino(7) □ Hindi/Indian dialect(8) □ Other(9)</th>
</tr>
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<tr>
<th>AG. Race/Ethnicity</th>
<th>□ White/Caucasian(1) □ Black/African-American(2) □ Hispanic/Latino(3): Please specify ____________</th>
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<tbody>
<tr>
<td>□ Asian/Pacific Islander(4): Please specify:</td>
<td>____________</td>
</tr>
<tr>
<td>□ American Indian/Alaskan Native(5): Please Specify ______</td>
<td></td>
</tr>
<tr>
<td>□ Indian(6)</td>
<td>____________</td>
</tr>
<tr>
<td>□ Middle Eastern(7)</td>
<td>____________</td>
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<tr>
<td>□ Other(8)</td>
<td>____________</td>
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<tr>
<th>AI. How long have you been homeless?</th>
<th>________</th>
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<thead>
<tr>
<th>AJ. Do you live with family/friends?</th>
<th>Yes(2) No(0)</th>
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<tr>
<th>AK. Size of Household?</th>
<th>________</th>
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6/15
Health Insurance
AL. Do you have health insurance? □ Yes(2) □ No(0)
AM. If Yes, what kind?
□ Medicare(1) □ MediCal (2) □ Private(3) _________
□ Self-pay / no insurance(4) □ Other(5)__________

AN. Employment (AO)
□ Employed full-time(1): Occupation__________
□ Employed part-time(2): Occupation__________
□ Retired(3): Prev. Occupation__________
□ Disability(4): Prev. Occupation__________
□ Unemployed/Laid Off(5) □ Housewife(6)

AP. Highest Level of Education
□ Did not attend school(1) □ Elementary School (Gr K-6)(2) □ Jr. High (Gr 7-9)(3) □ High School(10-12)(4)
□ Some College(5) □ College(6) □ Graduate Degree(7) □ Other Degree/Cert.(8)__________
AQ. Number of years of schooling? ________

Travel to Clinic
AR. What type of transportation do you use to come to the clinic and return home? Mark all that apply.
□ Bus(1) □ Car / Taxi(2) □ Walking(3) □ Bicycle / Motorcycle(4) □ Transportation services(5)
Specify________________
AS. How long does it take you to travel to the clinic?
_________ minutes
AT. How inconvenient is the transportation from your house?
Convenient(1) Not inconvenient(2) Somewhat inconvenient(3) Very inconvenient(4)
AU. Do you require an escort to help you come to the clinic? □ No(0) □ Yes(1)
AV. How difficult is it for you (and any escorts) to take time away from home or work to come for diabetic retinopathy follow-up visits?
Easy(0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)
AW. Given your age and physical condition, how physically difficult is it for you to come to the clinic?
Easy(0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)
AX. How safe do you feel when you are traveling to and from the clinic?
Safe(0) Neutral(1) Unsafe(2)

Costs of Diabetic retinopathy Medications and Follow-up Visits
AY. Do you take insulin/medicine for diabetes? □ Yes(2) □ No(0)
a. AZ. If YES: “Patients with diabetes sometimes have difficulty taking insulin/medicine the way the doctor prescribed. In the last 14 days, how many days have you missed taking at least one dose of your insulin/medicine?” # days: _________
□ Often (≥ 5 days)(3) □ Sometimes (3-4 days)(2) □ Rarely (1-2 days)(1) □ Never (0 days)(0)
BA. If NO, why? □ Not advised(1) □ Other(2) (specify) ________________
BB. If YES: How much do you pay for your diabetes medications/insulin every month? ________ □ N/A(6)
BC. If YES: How difficult for you are the costs of your diabetes medications/insulin? □ N/A(6)
Easy (0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)
Sources of Information about Diabetic retinopathy

Please list your sources of knowledge/information regarding diabetic retinopathy:

- Ophthalmologist & staff at clinic (BD): □ Yes (2) □ No (0)
- Pamphlets/Posters (BE): □ Yes (2) □ No (0)
- Family/relatives/friends (BF): □ Yes (2) □ No (0)
- Media (TV/Radio/internet) (BG) □ Yes (2) □ No (0)
- Primary Care Physician (BH) □ Yes (2) □ No (0)
- Other (BI) ____________

Disease Knowledge Questions

BJ. Is diabetic retinopathy related to blood vessel damage in the eye? □ Yes (2) □ No (0) □ Not sure (1)

BK. Is diabetic retinopathy related to damage to the retina? □ Yes (2) □ No (0) □ Not sure (1)

BL. If untreated, can diabetic retinopathy cause severe or total vision loss?
□ Yes (2) □ No (0) □ Not sure (1)

BM. Is vision loss from diabetic retinopathy permanent?
□ Yes (2) □ No (0) □ Not sure (1)

BN. Does diabetic retinopathy usually require treatment and/or follow-up for life?
□ Yes (2) □ No (0) □ Not sure (1)

Perceptions about Disease and Attending Follow-up

BO. How difficult is it for you to come for diabetic retinopathy follow-up visits every few months?
Easy (1) Not too difficult (2) Somewhat difficult (3) Very difficult (4)

BP. How important do you feel it is to attend follow-up visits for diabetic retinopathy?

Not too Important (1) Somewhat Important (2) Very Important (3)

BQ. If you are taking your medications and insulin to control your blood sugar and you don’t see any changes in
your vision, how important do you feel it is to attend your next follow-up visit as advised?

Not too Important (1) Somewhat Important (2) Very Important (3)

BR. In general would you say your diabetic retinopathy is:
Mild (1) Moderate (2) Severe (3)
Bars to Eye Care Service Utilization
(If applicable) Which of the following have been significant barriers for you in attending your follow-up diabetic retinopathy exam visits in the past year? Mark all that apply.

BS. Long clinic waits  □ Yes(2) □ No(0)
  BT. Long waiting times at clinic  □ Yes(2) □ No(0)
  BU. If Yes, how long have you waited? ____________
  BV. Long (additional) wait times for interpreters  □ Yes(2) □ No(0)

BW. Rescheduling difficulties  □ Yes(2) □ No(0)
  BX. The office calls to cancel and reschedule my appointments  □ Yes(2) □ No(0)
  BY. I have trouble rescheduling my appointments  □ Yes(2) □ No(0)
  BZ. I could not reschedule an appointment more than 6 months in advance  □ Yes(2) □ No(0)

CA. I was unhappy with the care I received here in the past  □ Yes(2) □ No(0)
  CE. If Yes, please explain: ________________________________

CB. Financial Barriers:  □ Yes(2) □ No(0)
  CC. Clinic visit fees  □ Yes(2) □ No(0)
  CD. Transportation costs  □ Yes(2) □ No(0)
  CE. Lost wages  □ Yes(2) □ No(0)
  CF. Other (Specify) ____________

CG. Unable to leave work responsibilities  □ Yes(2) □ No(0)
CH. Other medical or physical condition  □ Yes(2) □ No(0)
  CI. If Yes please specify __________________________

CL. Lack of an escort  □ Yes(2) □ No(0)
CJ. Other serious personal issues to take care of  □ Yes(2) □ No(0)
  CK. If Yes, please specify ______________________________

CL. Other incidental obligations  □ Yes(2) □ No(0)
CM. If Yes, please specify ____________________________

CN. Do you ever forget to come?  □ Yes(2) □ No(0)
CO. Do you ever miss an appointment because your eyes feel okay?  □ Yes(2) □ No(0)
CP. Do you ever miss an appointment because you don’t think it’s important to come for your regular glaucoma follow-up exams?  □ Yes(2) □ No(0)
CQ. Do you ever miss an appointment because you don’t feel safe when coming to clinic?  □ Yes(2) □ No(0)
CR. Do you have any other reasons why it might be difficult for you to come for your scheduled appointments? ________________________________________
Potential Strategies to Facilitate Regular Diabetic Retinopathy Follow-up

Which of the following would help you attend your regular diabetic retinopathy follow-up exams?

CT. Having a reminder a week before your scheduled date of visit (by phone, e-mail, text message, or letter)
   □ Yes(2) □ No(0)

CU. Having a mobile diabetic retinopathy van that comes to your area of residence once every few months on a specific day
   □ Yes(2) □ No(0)

CV. More education on the serious effects of diabetic retinopathy
   □ Yes(2) □ No(0)

CW. More education on why follow-up visits are important
   □ Yes(2) □ No(0)

CX. Parking vouchers
   □ Yes(2) □ No(0)

CY. Transportation service that brings you to clinic and takes you back home
   □ Yes(2) □ No(0)

CZ. Other strategies _____________________________________________________________

Strategies to Improve Patient Support

DA. Do you know anyone else who suffers from diabetic retinopathy?
   □ Yes(2) □ No(0)
   DB. If Yes, who?  Family(1)  Friend(2)  Contact through a support network(3)

DC. Do you know anyone who has lost his/her vision later in life?
   □ Yes(2) □ No(0)
   DD. If Yes, who?  Family(1)  Friend(2)  Contact through a support network(3)

DE. Do you have a support network?
   □ Yes(2) □ No(0)
   DF. If yes, who?  Family(1)  Friend(2)  Public Resource(3)
   DG. Specify:______________________________________________________________

DH. Has the clinic provided you with resources or a support network to help you manage your eye condition?
   □ Yes(2) □ No(0)
   DI. If yes, what are the resources? ____________

DJ. Do you feel like you would benefit from a support network of other people with diabetic retinopathy and/or an eye condition?
   □ Yes(2) □ No(0)
# AMD A. Patient Study #

<table>
<thead>
<tr>
<th>A. Patient Study #</th>
<th>B. Date:</th>
<th>C. Interviewer:</th>
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</thead>
<tbody>
<tr>
<td>□ ARMD treatment at Stanford Hospital and Clinics for at least 12 months</td>
<td>□ D. Dx of Age-Related Macular Degeneration (but not Glaucoma or Diabetic Retinopathy)</td>
<td></td>
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<tr>
<td>□ Wet (9)</td>
<td>□ Dry (10)</td>
<td></td>
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<tr>
<td>□ Age &gt;= 18 years</td>
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## INCLUSION CRITERIA

- Corrected Visual Acuity: H. OD: ______ I. OS: _______
- Uncorrected Visual Acuity: J. OD: ______ K. OS: _______

- N. Past EYE surgeries? □ Yes(2) □ No(0)
- O. (Specify: ________)

- P. Past AMD Procedures □ Yes (2) □ No(0)
- Q. Specify: HVF/GVF (1) Laser(2) Injections(3) Other(4)

- R. Past AMD Surgeries □ Yes(2) □ No(0)
- S. (Specify: ________)

- T. Patient Cancellation/NOS without rescheduling in 1mo □ Yes(2) □ No(0)
- U. #NOS in past 12mo: ________

- V. #Patient Cancellations in past 12mo: ________

- W. Total #Scheduled appointments in past 12mo: ________

- X. Diabetes Diagnosis: □ Yes (2) □ No (0)

- Y. In the past 12 months, have you seen an ophthalmologist outside of Stanford for macular degeneration? □ Yes (2) □ No (0)

- Z. If YES, how many AMD exams? ________ (if answer to above question is NO, put zero)

- AA. How long have you had AMD? ________

- AB. How were you diagnosed with AMD?
  - □ Did the ophthalmologist tell you that you have AMD during a routine eye exam?(1)
  - □ Or, did you have symptoms and then see an ophthalmologist?(2)

- AC. Do you have AMD: □ in one eye?(1) □ in both eyes?(2)

- AD. Date first seen at Stanford for AMD: ________

- AE. English Language Fluency □ English(1) □ Spanish(2)
  - □ Cantonese(3) □ Mandarin(4) □ Russian(5)
  - □ Vietnamese(6) □ Filipino(7) □ Hindi/Indian dialect(8) □ Other(9)

- AG. Race/Ethnicity
  - □ White/Caucasian(1)
  - □ Black/African-American(2)
  - □ Hispanic/Latino(3): Please specify: ________
  - □ Asian/Pacific Islander(4): Please specify: ________
  - □ American Indian/Alaskan Native(5): Please Specify: ________
  - □ Indian(6) ________
  - □ Middle Eastern(7)
  - □ Other(8) ________

- AH. What type of Housing do you live in?
  - □ Own/Rent(1)
  - □ Assisted Living (5)
  - □ Public Housing(2)
  - □ Shelter/Group/Transitional Home(3)
  - □ Homeless(4): ________

- AI. How long have you been homeless? ________

- AJ. Do you live with family/friends? □ Yes(2) □ No(0)

- AK. Size of Household? ________
Health Insurance
AL. Do you have health insurance? □ Yes(2) □ No(0)

AM. If Yes, what kind?
□ Medicare(1) □ MediCal (2) □ Private(3) □ Self-pay / no insurance(4) □ Other(5)

AN. Employment (AO)
□ Employed full-time(1): Occupation________
□ Employed part-time(2): Occupation________
□ Retired(3): Prev. Occupation________
□ Disability(4): Prev. Occupation________
□ Unemployed/Laid Off(5)
□ Housewife(6)

AP. Highest Level of Education
□ Did not attend school(1) □ Elementary School (Gr K-6)(2) □ Jr. High (Gr 7-9)(3) □ High School(10-12)(4)
□ Some College(5) □ College(6) □ Graduate Degree(7) □ Other Degree/Cert.(8)

AQ. Number of years of schooling? ________

Travel to Clinic
AR. What type of transportation do you use to come to the clinic and return home? Mark all that apply.
□ Bus(1) □ Car / Taxi(2) □ Walking(3) □ Bicycle / Motorcycle(4) □ Transportation services(5)
Specify________

AS. How long does it take you to travel to the clinic?

________ minutes

AT. How inconvenient is the transportation from your house?

Convenient(0) Not inconvenient(1) Somewhat inconvenient(2) Very inconvenient(3)

AU. Do you require an escort to help you come to the clinic? □ No(0) □ Yes(1)

AV. How difficult is it for you (and any escorts) to take time away from home or work to come for AMD follow-up visits?

Easy(0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)

AW. Given your age and physical condition, how physically difficult is it for you to come to the clinic?

Easy(0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)

AX. How safe do you feel when you are traveling to and from the clinic?

Safe(0) Neutral(1) Unsafe(2)

Costs of AMD Medications and Follow-up Visits
AY. Do you get intravitreal injections for AMD? □ Yes(2) □ No(0)

BA. If NO, why? □ Not advised(1) □ Other(2) (specify)________

BB. If YES: How much do you pay for your intravitreal injections every month? ________ N/A

BC. If YES: How difficult for you are the costs of your intravitreal injections? □ N/A(6)

Easy(0) Not too difficult(1) Somewhat difficult(2) Very difficult(3)
Sources of Information about AMD

Please list your sources of knowledge/information regarding AMD:

- Ophthalmologist & staff at clinic (BD): □ Yes (2) □ No (0)
- Pamphlets/Posters (BE): □ Yes (2) □ No (0)
- Family/relatives/friends (BF): □ Yes (2) □ No (0)
- Media (TV/Radio/internet) (BG): □ Yes (2) □ No (0)
- Primary Care Physician (BH): □ Yes (2) □ No (0)
- Other (BL) __________

Disease Knowledge Questions

BJ. Is AMD related to damage to the macula? □ Yes (2) □ No (0) □ Not sure (1)

BK. Is AMD related to damage to the retina? □ Yes (2) □ No (0) □ Not sure (1)

BL. If untreated, can AMD cause severe or total vision loss?
   □ Yes (2) □ No (0) □ Not sure (1)

BM. Is vision loss from AMD permanent?
   □ Yes (2) □ No (0) □ Not sure (1)

BN. Does AMD usually require treatment and/or follow-up for life?
   □ Yes (2) □ No (0) □ Not sure (1)

Perceptions about Disease and Attending Follow-up

BO. How difficult is it for you to come for AMD follow-up visits every few months?
   Easy (1) Not too difficult (2) Somewhat difficult (3) Very difficult (4)

BP. How important do you feel it is to attend follow-up visits for AMD?
   Not too important (1) Somewhat important (2) Very important (3)

BQ. If you are getting intravitreal injections and you don't see any changes in your vision, how important do you feel it is to attend your next follow-up visit as advised?
   Not too important (1) Somewhat important (2) Very important (3)

BR. In general would you say your AMD is:
   Mild (1) Moderate (2) Severe (3)
Barriers to Eye Care Service Utilization

(If applicable) Which of the following have been significant barriers for you in attending your follow-up AMD exam visits in the past year? Mark all that apply.

BS. Long clinic waits

BT. Long waiting times at clinic

BU. If Yes, how long have you waited? ____________

BV. Long (additional) wait times for interpreters

BW. Rescheduling difficulties

BX. The office calls to cancel and reschedule my appointments

BY. I have trouble rescheduling my appointments

BZ. I could not reschedule an appointment more than 6 months in advance

CA. I was unhappy with the care I received here in the past

CE. If Yes, please explain: __________________________________________________________

CB. Financial Barriers:

CC. Clinic visit fees

CD. Transportation costs

CE. Lost wages

CF. Other (Specify) ________________

CG. Unable to leave work responsibilities

CH. Other medical or physical condition

CI. If Yes please specify ______________________

CL. Lack of an escort

CJ. Other serious personal issues to take care of

CK. If Yes, please specify ______________________

CL. Other incidental obligations

CM. If Yes, please specify ________________

CN. Do you ever forget to come?

CO. Do you ever miss an appointment because your eyes feel okay?

CP. Do you ever miss an appointment because you don’t think it’s important to come for your regular glaucoma follow-up exams?

CQ. Do you ever miss an appointment because you don’t feel safe when coming to clinic?

CR. Do you have any other reasons why it might be difficult for you to come for your scheduled appointments?

__________________
(For Interviewer to Complete)

CS. What was the most important reason of those indicated above (mark question Letter)? N/A

Potential Strategies to Facilitate Regular AMD Follow-up

Which of the following would help you attend your regular AMD follow-up exams?

CT. Having a reminder a week before your scheduled date of visit (by phone, e-mail, text message, or letter)

- Yes (2)
- No (0)

CU. Having a mobile AMD van that comes to your area of residence once every few months on a specific day

- Yes (2)
- No (0)

CV. More education on the serious effects of AMD

- Yes (2)
- No (0)

CW. More education on why follow-up visits are important

- Yes (2)
- No (0)

CX. Parking vouchers

- Yes (2)
- No (0)

CY. Transportation service that brings you to clinic and takes you back home

- Yes (2)
- No (0)

CZ. Other strategies ____________________________________________________________

Strategies to Improve Patient Support

DA. Do you know anyone else who suffers from AMD?

DB. If Yes, who? Family(1) Friend(2) Contact through a support network(3)

- Yes (2)
- No (0)

DC. Do you know anyone who has lost his/her vision later in life?

DD. If Yes, who? Family(1) Friend(2) Contact through a support network(3)

- Yes (2)
- No (0)

DE. Do you have a support network?

DF. If yes, who? Family(1) Friend(2) Public Resource(3)

DG. Specify: ________________________________________________________________

DH. Has the clinic provided you with resources or a support network to help you manage your eye condition?

DI. If yes, what are the resources? __________

DJ. Do you feel like you would benefit from a support network of other people with AMD and/or an eye condition?

- Yes (2)
- No (0)