Appendix

Glaucoma Outcomes Survey (GOS)

Impact of Vision on Your Life

Please click on the "Impact of Vision on Your Life" link below to begin the survey. Your completion of the survey is greatly appreciated.

This survey asks about how your vision impacts your life. Please answer each question by clicking the box to the left of your answer. Once the box is checked, you will advance to the next question.

How often do you wear corrective lenses such as glasses or contact lenses when you are awake?

I wear glasses or contact lenses all the time or almost all the time	1
I wear glasses or contact lenses most of the time	2
I wear glasses or contact lenses some of the time	3
I wear glasses or contact lenses a little of the time	4
I never wear glasses or contact lenses	5

If you use corrective lenses such as glasses or contact lenses, we want to know about your vision while wearing your corrective lenses. If you use corrective lenses, when you answer the questions please think about your vision and how well you see when you are **wearing your corrective lenses**.

During the survey, you can return to the previous question by clicking the left arrow at the bottom of the page.

1. Because of your eyesight, how difficult is it for you to watch television? [p. 9]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to watch television because of eyesight	5
Unable to watch television for another reason	6

2. Because of your eyesight, how difficult is it for you to go up or down steps, stairs, or curbs? [p. 10]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to go up or down steps, stairs, or curbs because of eyesight	5
Unable to go up or down steps, stairs, or curbs for another reason	6

3. Because of your eyesight, how difficult is it for you to get around outdoors? [p. 11]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to get around outdoors because of eyesight	5
Unable to get around outdoors for another reason	6

Remember that *if* you use corrective lenses such as glasses or contact lenses, please think about your vision and how well you see when you are **wearing your corrective lenses**.

4. How difficult is it for you to see street signs during the day? [p. 13]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see street signs during the day	5

5. How difficult is it for you to see indoors in dim light? [p. 14]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see at night in dim light	5

6. How difficult is it for you to see street signs at night in dim light? [p. 15]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see street signs at night	5

7. Because of your eyesight, how difficult is it for you to drive at night? [p. 16]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to drive at night because of eyesight	5
Unable to drive at night for another reason	6

8. How difficult is it for you to drive due to glare from oncoming headlights? [p. 17]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to drive because of glare	5
Unable to drive because of eyesight unrelated to glare	6
Unable to drive for another reason	7

9. Because of your eyesight, how difficult is it for you to see different colors? [p. 18]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see different colors	5

Remember that *if* you use corrective lenses such as glasses or contact lenses, please think about your vision and how well you see when you are **wearing your corrective lenses**.

10. Because of your eyesight, how difficult is it for you to see people who approach you from the side? [p. 20]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see people who approach from the side	5

11. How difficult is it for you to see things off to the side of your vision? [p. 21]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see things off to the side of my vision.	5

12. Because of your eyesight, how difficult is it for you to recognize people when they are close to you? [p. 22]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to recognize people when they are close to me	5

13. Because of your eyesight, how difficult is it for you to recognize people from across a room? [p. 23]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to recognize people from across a room	5

14. Because of your eyesight, how difficult is it for you to read a printed newspaper or book? [p. 24]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to read a printed newspaper or book because of eyesight	5
Unable to read a printed newspaper or book for another reason	6

15. Because of your eyesight, how difficult is it for you to read small print on medicine bottles, telephone books, legal forms, or bills you receive in the mail? [p. 25]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to read small print because of eyesight	5
Unable to read small print for another reason	6

16. Because of your eyesight, how difficult is it for you to find an item on a crowded shelf? [p. 26]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to find an item on a crowded shelf because of eyesight	5
Unable to find an item on a crowded shelf for another reason	6

17. Because of your eyesight, how difficult is it for you to use a computer? [p. 27]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to use a computer because of eyesight	5
Do not use a computer for another reason	6

18. Have you increased the font size, brightness, or contrast on your computer to make it easier to use? [p. 28]

No	1
Yes	2

19. Because of your eyesight, how difficult is it for you to use a cellphone? [p. 29]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to use a cellphone because of eyesight	5
Do not use a cellphone for another reason	6

20. Have you increased the font size, brightness, or contrast on your cellphone to make it easier to use? [p. 30]

No	1
Yes	2

21. Because of your eyesight, how difficult is it for you to write? [p. 31]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to write because of eyesight	5
Unable to write for another reason	6

22. Because of your eyesight, how difficult is it for you to do housework? [p. 32]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to do housework because of eyesight…….5	
Unable to do housework for another reason	6

23. Because of your eyesight, how limited are you in doing your daily activities? [p. 33]

Not limited at all	1
A little limited	2
Somewhat limited	3
Very limited	4
Unable to do daily activities because of eyesight	5
Unable to do daily activities for another reason	6

24. Because of your eyesight, how much less do you accomplish than you would like? [p. 34]

I accomplish as much as I would like	1
I accomplish a little less than I would like	2
I accomplish somewhat less than I would like	3
I accomplish a lot less than I would like because of eyesight	4
I accomplish a lot less than I would like for another reason	5

25. Because of your eyesight, how limited are you in how long you can work at a paying job? [p.35]

I did not have a paying job in the last 7 days	1
Not limited at all	2
A little limited	3
Somewhat limited	4
Very limited	5
Unable to work because of eyesight	6
Do not work at a paying job for another reason.	7

26. How difficult is it for you to see in bright sunlight? [p. 36]

Not difficult at all	1
A little difficult	2
Somewhat difficult	3
Very difficult	4
Unable to see in bright sunlight	5

27. In the last 7 days, how much of a problem did you have with eye redness? [p. 37]

No problem at all	1
A little bit of a problem	2
Somewhat of a problem	3
Very much of a problem	4

28. In the last 7 days, how much of a problem did you have with your eyes being sensitive to indoor lights? [p. 38]

No problem at all	1
A little bit of a problem	2
Somewhat of a problem	3
Very much of a problem	4

29. In the last 7 days, how much of a problem did you have with your eyes being sensitive to sunlight? [p. 39]

No problem at all	1
A little bit of a problem	2
Somewhat of a problem	3
Very much of a problem	4

30. In the last 7 days, how much of a problem did you have with blurry vision? [p. 40]

No problem at all	1
A little bit of a problem	2
Somewhat of a problem	3
Very much of a problem	4

31. In the last 7 days, how much of a problem did you have with itching in or around your eyes? [p. 41]

No problem at all	1
A little bit of a problem	2
Somewhat of a problem	3
Very much of a problem	4

32. In the last 7 days, how often did you feel like something was irritating your eyes? [p. 42]

Never	1
Rarely	2
Sometimes	3
Usually	4
Always	5

33. In the last 7 days, how drowsy or tired did you feel during the day from the drops you used to treat your glaucoma? [p. 43]

Did not feel drowsy or tired at all	1
Felt a little drowsy or tired	2
Felt somewhat drowsy or tired	3
Felt very drowsy or tired	4
Did not use drops to treat my glaucoma in the last 7 days	5

34. In the last 7 days, how annoyed did you feel by your eyesight? [p. 44]

Did not feel annoyed at all	1
Felt a little bit annoyed	2
Felt somewhat annoyed	3
Felt very annoyed	4

35. In the last 7 days, how angry did you feel by your eyesight? [p. 45]

Did not feel angry at all	1
Felt a little bit angry	2
Felt somewhat angry	3
Felt very angry	4

36. In the last 7 days, how concerned or worried were you about your safety at home because of your eyesight? [p. 46]

Did not feel concerned or worried at all about my safety at home……	1
Felt a little bit concerned or worried about my safety at home…..……	2
Felt somewhat concerned or worried about my safety at home……	3
Felt very concerned or worried about my safety at home……..…….	4
Felt concerned or worried about my safety at home for another reason.	5

37. In the last 7 days, how worried were you about your eyesight? [p. 47]

Not worried at all about my eyesight	1
A little bit worried about my eyesight	2
Somewhat worried about my eyesight	3
Very worried about my eyesight	4

38. In the last 7 days, how worried were you about losing your job because of your eyesight? [p.48]

I did not have a job in the last 7 days	1
Not worried at all about losing my job	2
A little bit worried about losing my job	3
Somewhat worried about losing my job	4
Very worried about losing my job	5
Worried about losing my job for another reason	6

39. Because of your eyesight, how much do you have to rely on other people to do things? [p. 49]

Do not rely on other people	1
Rely a little on other people	2
Rely somewhat on other people	3
Rely a lot on other people	4
Rely on other people for another reason	5

40. In the last 7 days, how concerned were you about how your glaucoma treatment affects the way you look? [p. 50]

Not concerned at all about how my glaucoma treatment affects the way I look	1
A little bit concerned about how my glaucoma treatment affects the way I look…	2
Somewhat concerned about how my glaucoma treatment affects the way I look	3
Very concerned about how my glaucoma treatment affects the way I look	4
Concerned about the way I look for another reason	5

41. In the last 7 days, how fearful were you about what might happen in the future because of glaucoma? [p. 51]

Not fearful at all about what might happen in the future	1
A little bit fearful about what might happen in the future	2
Somewhat fearful about what might happen in the future	3
Very fearful about what might happen in the future	4
Fearful about what might happen in the future for another reason	5

42. Because of your glaucoma treatment, are you less interested in sex? [p. 52]

No	1
Yes, a little less interested in sex because of my glaucoma treatment	2
Yes, somewhat less interested in sex because of my glaucoma treatment	3
Yes, a lot less interested in sex because of my glaucoma treatment	4

43. How satisfied are you with your microinvasive glaucoma surgery (MIGS)? [p. 53]

I have not had microinvasive glaucoma surgery (MIGS)	1
I don't know if I have had microinvasive glaucoma surgery (MIGS)	2
Completely satisfied	3
Very satisfied	4
Somewhat satisfied	5
Somewhat dissatisfied	6
Very dissatisfied	7
Completely dissatisfied	8

44. Based on what you know, do you think your glaucoma is mild, moderate, or severe? [p. 54]

Mild glaucoma	1
Moderate glaucoma	2
Severe glaucoma	3
I do not have glaucoma yet	4
I do not know the severity of my glaucoma	5

45. How long have you had glaucoma? [p. 55]

Less than 5 years	1
6-10 years	2
11-20 years	3
21-40 years	4
41 years or longer	5
Do not know	6

46. What is your gender? [pp. 56-57]

Woman	1
Man	2
Other	3

Please specify "Other" gender: _____

47. Please indicate your age. [p. 58]

18-20 years	1
21-40 years	2
41-50 years	3
51-60 years	4
61-70 years	5
71-80 years	6
81 years or older	7

48. What is your ethnicity? [p. 59]

Hispanic or Latino	1
Not Hispanic or Latino	2

49. What is your race? (check all that apply) [p. 60]

Black or African American	1
American Indian or Alaska Native	2
Native Hawaiian or Pacific Islander	3
Asian	4
White	5
Other	6

Please specify "Other" race: _____

50. What is the highest grade or level of school that you have completed? [p. 61]

8th grade or less	1
Some high school, but did not graduate	2
High school graduate or GED	3
Some college or 2-year degree	4
4-year college graduate	5
More than 4-year college degree	5

51. Compared to 3 months ago, how is your quality of life related to your glaucoma now? [p. 62]

Much better	1
A little better	2
About the same	3
A little worse	4
Much worse	5

52. Compared to 3 months ago, how well can you perform your daily tasks now? [p. 63]

Much better	1
A little better	2
About the same	3
A little worse	4
Much worse	5

Thank you for completing this survey.

Your participation will help us evaluate glaucoma and its treatments.

END TIME: