**EPIDEMIOLOGY OF DIABETES INTERVENTION AND COMPLICATIONS**
**National Eye Institute Visual Functioning Questionnaire – 25 (VFQ-25) Version 2000**

This form should be completed quadrennially in conjunction with the ophthalmological exam.

Send a copy of this form to the Coordinating Center in the monthly forms mailing. Retain a copy in the clinic files.

**A. IDENTIFYING INFORMATION**

1. Clinic Number: __ __
2. Patient ID Number: __ __ __ __ __
3. Patient's Initials: __ __ __
4. Date Form Completed: __ __/__ __/__ __ (Month Day Year)
5. EDIC Follow-Up Year: __ __

The following is a survey with statements about problems which involve your vision or feelings that you have about your vision condition. After each question please choose the response that best describes your situation. Please answer all the questions as if you were wearing your glasses or contact lenses (if any). Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about vision problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.

2. Please answer every question (unless you are asked to skip questions because they don't apply to you).

3. Answer the questions by circling the appropriate number.

4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.

5. Please complete the questionnaire before leaving the center and give it to a member of the project staff. Do not take it home.

6. If you have any questions, please feel free to ask a member of the project staff, and they will be glad to help you.

**B. PART 1 - GENERAL HEALTH AND VISION**

1. In general, would you say your overall health is: (Check One)

| | |
|---|---|
| Excellent | (1) |
| Very Good | (2) |
| Good | (3) |
| Fair | (4) |
| Poor | (5) |

2. At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind? (Check One)

| | |
|---|---|
| Excellent | (1) |
| Good | (2) |
| Fair | (3) |
| Poor | (4) |
| Very Poor | (5) |
| Completely Blind | (6) |

3. How much of the time do you worry about your eyesight? (Check One)

| | |
|---|---|
| None of the time | (1) |
| A little of the time | (2) |
| Some of the time | (3) |
| Most of the time | (4) |
| All of the time? | (5) |

4. How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is: (Check One)

| | |
|---|---|
| None | (1) |
| Mild | (2) |
| Moderate | (3) |
| Severe, or | (4) |
| Very severe? | (5) |

**C. PART 2 - DIFFICULTY WITH ACTIVITIES**

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

5. How much difficulty do you have reading ordinary print in newspapers? Would you say you have: (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

6. How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say: (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

7. Because of your eyesight, how much difficulty do you have finding something on a crowded shelf? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

8. How much difficulty do you have reading street signs or the names of stores? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

9. Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

10. Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

11. Because of your eyesight, how much difficulty do you have seeing how people react to things you say? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

12. Because of your eyesight, how much difficulty do you have picking out and matching your own clothes? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

13. Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants? (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Stopped doing this because of your eyesight | (5) |
| Stopped doing this for other reasons or not interested in doing this | (6) |

14. Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events? (Check One)

- No difficulty at all (1)
- A little difficulty (2)
- Moderate difficulty (3)
- Extreme difficulty (4)
- Stopped doing this because of your eyesight (5)
- Stopped doing this for other reasons or not interested in doing this (6)

15. Are you currently driving, at least once in a while? (Check One)

- Yes (Skip To Question 15c) (1)
- No (2)

15a. IF NO: Have you never driven a car or have you given up driving? (Check One)

- Never drove (Skip To Part 3, Question 17) (1)
- Gave up (2)

15b. IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons? (Check One)

- Mainly eyesight (Skip To Part 3) (1)
- Mainly other reasons (Skip To Part 3) (2)
- Both eyesight and other reasons (Skip To Part 3) (3)

15c. IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have: (Check One)

- No difficulty at all (1)
- A little difficulty (2)
- Moderate difficulty (3)
- Extreme difficulty (4)

16. How much difficulty do you have driving at night? Would you say you have: (Check One)

- No difficulty at all (1)
- A little difficulty (2)
- Moderate difficulty (3)
- Extreme difficulty (4)
- Have you stopped doing this because of your eyesight (5)
- Have you stopped doing this for other reasons or not interested in doing this (6)

16A. How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have: (Check One)

| | |
|---|---|
| No difficulty at all | (1) |
| A little difficulty | (2) |
| Moderate difficulty | (3) |
| Extreme difficulty | (4) |
| Have you stopped doing this because of your eyesight | (5) |
| Have you stopped doing this for other reasons or not interested in doing this | (6) |

**D. PART 3 - RESPONSES TO VISION PROBLEMS**

The next questions are about how things you do may be affected by your vision. For each one, please circle the number to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

| READ CATEGORIES: | (Circle One On Each Line) All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|
| 17. Do you accomplish less than you would like because of your vision? | (1) | (2) | (3) | (4) | (5) |
| 18. Are you limited in how long you can work or do other activities because of your vision? | (1) | (2) | (3) | (4) | (5) |
| 19. How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say: | (1) | (2) | (3) | (4) | (5) |

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

| READ CATEGORIES: | (Circle One On Each Line) Definitely true | Mostly true | Not sure | Mostly false | Definitely false |
|---|---|---|---|---|---|
| 20. I stay home most of the time because of my eyesight | (1) | (2) | (3) | (4) | (5) |
| 21. I feel frustrated a lot of the time because of my eyesight | (1) | (2) | (3) | (4) | (5) |
| 22. I have much less control over what I do, because of my eyesight | (1) | (2) | (3) | (4) | (5) |
| 23. Because of my eyesight, I have to rely too much on what other people tell me | (1) | (2) | (3) | (4) | (5) |
| 24. I need a lot of help from others because of my eyesight | (1) | (2) | (3) | (4) | (5) |
| 25. I worry about doing things that will embarrass myself or others, because of my eyesight | (1) | (2) | (3) | (4) | (5) |

Type or print name of person completing this form:

_____

Certification Number (if any)

__ __ - __ __