



Patient ID Number	<input type="text"/>						
	Site	Sub-site		Sequential ID			

## SEARCH Eye Vision History Form

1. Do you have an optometrist or ophthalmologist that you go to? [haveEyeDoc\\_VISN](#)

1  Yes → If Yes, would you give his/her name and telephone number?

Name:	Telephone Number
<hr/>	<input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Mailing Address:

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City	State	Zip Code
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2  No → If No, skip to question 2.

3  Don't know → If Don't know, skip to question 2.

4  Refused → If Refused, skip to question 2.

2. Have you ever had laser treatment or injections to the eye because of diabetic retinopathy? [laserTreat\\_VISN](#)

1  Yes – Right eye only

4  No

2  Yes – Left eye only

5  Don't know

3  Yes – Both eyes

6  Refused

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0904).

**FOR STUDY USE ONLY**

Were there any difficulties in obtaining the retinal images? 1  Yes 2  No [difficulties\\_VISN](#)



If yes, please check what this was due to (check the main reason): [diffReason\\_VISN](#)

- 1  camera
- 2  participant
- 3  operator
- 4  other (specify) [diffDetail\\_VISN](#) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

[d\\_VISN](#)

Date Completed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Completed by	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month	Day	Year					
Date Reviewed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Reviewer Code	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month	Day	Year					
Date Entered	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Data Entry Code	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month	Day	Year					