



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?

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

haveeyedoc_visin

Name:

Telephone Number

_____ -

Mailing Address:

City

State

Zip Code

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_visin](#)

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 **diffreason_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) _____
- _____
- _____

Date Completed
compldat

Month		Day		Year			

Completed by
complby

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Date Reviewed
revwdate

Month		Day		Year			

Reviewer Code
revwby

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Date Entered
enterdat

Month		Day		Year			

Data Entry Code
enterdat

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