

QUESTIONNAIRE: OPORTO MYOPIA STUDY

This questionnaire consists of 33 quick and simple questions (3–5 minutes). Its purpose is statistical use, serving as a tool to continually improve clinical practice and ocular health among patients of the Ophthalmology Department at Centro Hospitalar e Universitário de Santo António (Unidade Local de Saúde de Santo António).

All data will be analyzed anonymously, only for statistical purposes, without identifying individual responses.

The questionnaire is divided into 5 parts:

- 1. GENERAL DEMOGRAPHIC DATA – 8 questions
- 2. GENERAL HEALTH DATA – 2 questions
- 3. OCULAR HEALTH DATA – 6 questions
- 4. LIFESTYLE DURING CHILDHOOD AND ADOLESCENCE – 7 questions
- 5. CURRENT LIFESTYLE DATA – 10 questions

* *Indicates a required question*

PART 1 — GENERAL DEMOGRAPHIC DATA

1. INITIALS OF NAME *

2. CLINICAL RECORD NUMBER *

3. COUNTRY OF BIRTH

4. GENDER *

- Female
- Male
- Unspecified

5. AGE *

6. HEIGHT (centimeters) *

7. WEIGHT (kilograms) *

8. MUNICIPALITY OF RESIDENCE *

9. POSTAL CODE (first 4 digits) *

10. ACADEMIC DEGREE

- 4th grade
- 6th grade
- 9th grade
- 12th grade
- Bachelor's / Master's
- Doctorate

PART 2 — GENERAL HEALTH DATA

11. HISTORY OF ALLERGIC DISEASES (check all that apply) *

- None
- Atopy
- Rhinitis
- Asthma
- Dermatitis
- Other: _____

12. HISTORY OF AUTOIMMUNE OR CONNECTIVE TISSUE DISEASES (check all that apply) *

- None
- Rheumatoid arthritis
- Lupus
- Spondylitis
- Thyroid disease
- Polymyositis / Dermatomyositis
- Marfan syndrome
- Pseudoxanthoma elasticum
- Ehlers-Danlos syndrome
- Other: _____

PART 3 — OCULAR HEALTH DATA

13. DO YOU USUALLY HAVE EYE SYMPTOMS IN THE RIGHT EYE? (check all that apply) *

- No symptoms
- Itching (pruritus)
- Stinging
- Grittiness
- Dry eye sensation
- Blurred vision sensation
- Tearing
- Red eye
- Discharge
- Photophobia (marked light discomfort)
- Blurred vision at certain times of day that improves after blinking
- Other: _____

14. DO YOU USUALLY HAVE EYE SYMPTOMS IN THE LEFT EYE? (check all that apply) *

- No symptoms
- Itching (pruritus)
- Stinging
- Grittiness
- Dry eye sensation
- Blurred vision sensation
- Tearing
- Red eye
- Discharge
- Photophobia (marked light discomfort)
- Blurred vision at certain times of day that improves after blinking
- Other: _____

15. DO YOU USE ANY EYE DROPS IN THE RIGHT EYE? *

- Yes
- No

If yes, please specify: _____

16. DO YOU USE ANY EYE DROPS IN THE LEFT EYE? *

- Yes
- No

If yes, please specify: _____

17. FAMILY HISTORY OF MYOPIA

- Yes
- No
- Don't know

18. PERSONAL HISTORY OF CORNEAL ECTASIA (e.g., keratoconus) *

- No
- Yes, right eye
- Yes, left eye

Yes, both eyes

19. FAMILY HISTORY OF CORNEAL ECTASIA (e.g., keratoconus) *

Yes

No

Don't know

20. USE OF CONTACT LENSES *

No

Right eye

Left eye

Both eyes

PART 4 — LIFESTYLE DURING CHILDHOOD AND ADOLESCENCE

21. TYPE OF SCHOOL ATTENDED MOSTLY DURING CHILDHOOD/ADOLESCENCE

- Public
- Private

22. WHERE DID YOU USUALLY SPEND YOUR RECESS TIME?

- Indoors
- Outdoors

23. AGE WHEN YOU STARTED USING TOUCHSCREEN DEVICES (PHONE/TABLET)

- Up to 5 years
- 5–9 years
- 10–14 years
- 15–20 years
- After 20 years

24. HABITUAL USE OF VIDEO GAME CONSOLES DURING CHILDHOOD/ADOLESCENCE

- Yes
- No

25. DID YOU REGULARLY PRACTICE OUTDOOR EXTRACURRICULAR ACTIVITIES DURING CHILDHOOD/ADOLESCENCE (sports, recreational activities, outdoor play...)?

- Yes
- No

26. DID YOU REGULARLY PRACTICE NEAR-VISION EXTRACURRICULAR ACTIVITIES DURING CHILDHOOD/ADOLESCENCE (language learning, reading/studying, musical instruments, drawing/painting, other arts...)?

- Yes
- No

27. WHICH TYPE OF EXTRACURRICULAR ACTIVITIES WAS MOST PREDOMINANT DURING CHILDHOOD/ADOLESCENCE?

- Outdoor activities
- Near-vision activities

PART 5 — CURRENT LIFESTYLE DATA

28. ON AVERAGE, HOW MANY HOURS PER WEEK DO YOU SPEND OUTDOORS? *

- Never
- 1–5 hours
- 5–10 hours
- 10–15 hours
- 15–20 hours
- 20–25 hours
- 25–30 hours
- More than 30 hours

29. WHEN SPENDING TIME OUTDOORS, DO YOU WEAR SUNGLASSES? *

- Never
- Less than half of the time
- More than half of the time

30. ON AVERAGE, HOW MANY HOURS PER WEEK DO YOU PRACTICE PHYSICAL ACTIVITY? *

- Never
- 1–2 hours
- 3–4 hours
- 5–6 hours
- 7–8 hours
- 9–10 hours
- More than 10 hours

31. ARE YOU REGULARLY EXPOSED TO AIR CONDITIONING AT HOME AND/OR AT WORK? *

- Yes
- No

32. DOES YOUR JOB INCLUDE THE USE OF A COMPUTER OR OTHER SCREENS? *

- Yes
- No

33. ON AVERAGE, HOW MANY HOURS PER DAY DO YOU USE SCREENS? *

- Never
- 1–2 hours
- 3–4 hours
- 5–6 hours
- 7–8 hours
- 9–10 hours
- More than 10 hours

34. ON AVERAGE, HOW MANY HOURS PER DAY DO YOU SPEND READING OR WRITING?

*

- Never
- 1–2 hours

- 3–4 hours
- 5–6 hours
- 7–8 hours
- 9–10 hours
- More than 10 hours

35. WHEN SLEEPING, WHICH POSITION IS MOST COMMON? *

- Face down
- Face up
- No predominance

36. ON MOST DAYS, WHICH SIDE OF YOUR FACE IS ON THE PILLOW? *

- Right side
- Left side
- No predominance

37. HOW OFTEN DO YOU RUB/SCRATCH YOUR RIGHT EYE? *

- No
- 1–5 times/day
- 6–10 times/day
- 11–15 times/day
- 16–20 times/day
- More than 20 times/day

38. HOW OFTEN DO YOU RUB/SCRATCH YOUR LEFT EYE? *

- No
- 1–5 times/day
- 6–10 times/day
- 11–15 times/day
- 16–20 times/day
- More than 20 times/day

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