DoCEG Health Questionnaire

PAPER COPY TO BE COMPLETED BY THE PARENT/GUARDIAN AT HOME

Please provide your child's unique participant ID.
(this will have been given to you by Occuity).
This will be used to link answers with measurement data. _____

What is your relationship to the child? (Please circle)

Mother Father Other (please specify):
_____

ONE-TIME QUESTIONS

Personal details

What is your child's date of birth? (Day/Month/Year) _____

What is your child's biological sex (i.e. sex assigned at birth)? (Please circle)

Male Female Unsure / Choose not to disclose

What is your child's ethnicity? _____

OR unsure / choose not to disclose

Was your child born prematurely?

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details, such as gestational age, birth weight, and special care / therapy:

BIANNUAL QUESTIONS

The following questions will help us to interpret the measurement data that we collect for this study.

Your child's eyes

Does your child use "refractive correction", e.g. glasses or contact lenses?

Yes* No Sometimes* Unsure / Choose not to disclose

*If "Yes", please provide details:

What age were they when they started wearing glasses/contacts? _____

Type of vision without glasses/contacts (Please circle)

- Blurred vision for near objects
- Blurred vision for distant objects
- Blurred vision for both near and distant objects
- Other (please specify): _____
- Unsure / Choose not to disclose

Is your child undergoing (or has your child previously undergone) any "myopia control" treatment for their short-sightedness? (Please circle)

- None
- Atropine eye drops
- Orthokeratology / Ortho-K contact lenses
- Light-based therapy:
    - Repeated low-level red light therapy / photobiomodulation (e.g. EyeRising)
    - Dopavision MyopiaX
- Glasses with "treatment zones":
    - Defocus Incorporated Multiple Segments (DIMS) - Hoya MiYOSMART
    - Highly Aspherical Lenslet Target (HALT) technology - Essilor Stellest
    - Diffusion Optics Technology (DOT) – SightGlass Vision
    - Cylindrical Annular Refractive Element (CARE) - ZEISS MyoCare
- Contact lenses with "treatment zones":
    - Peripheral defocus - CooperVision MiSight
    - Extended depth of focus - Mark'ennovy MYLO
- Other: (please specify): _____
- Unsure / Choose not to disclose

Please provide any further details that are relevant to your child's treatment plan:

Is your child taking part in any other research studies? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

Does your child have visual loss/impairment that *cannot* be corrected with glasses/contacts? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

Has your child ever had a disease that affected their eyes? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

Has your child ever had an injury that affected their eyes? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

Has your child ever had surgery or laser damage affecting their eyes? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

Your child's family

Do/did any of your child's immediate relatives (e.g. parents or siblings) use glasses/contacts? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

What age were they when they started wearing glasses/contacts? _____

Type of vision without glasses/contacts (Please circle)

- Blurred vision for near objects
- Blurred vision for distant objects
- Blurred vision for both near and distant objects
- Other (please specify): _____
- Unsure / Choose not to disclose

Do/did any of your child's immediate relatives have an eye condition, such as glaucoma, retinitis pigmentosa, colour-blindness? (Please circle)

Yes* No Unsure / Choose not to disclose

*If "Yes", please provide details:

Please provide any other details about their relatives that you think are relevant:

Your child's lifestyle

The following questions are about the time your child spends *outside of school*.

Please enter the postcode of your child's primary address

_____

On a typical day (over the last three months), how much time does your child spend outdoors?

School days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Non-school days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

On a typical day (over the last three months), how much time does your child spend on "near-work", e.g. reading, using electronic devices, table-top crafts, boardgames, etc?

School days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Non-school days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Of the time spent on "near work", how long is spent using electronic devices, e.g. smartphones, tablets, laptops, etc?

School days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Non-school days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

The following questions are about the time your child spends *outside of school*.

On a typical day (over the last three months), how much time does your child spend *seeing movement* around them – this could include traveling in a vehicle, *as long as they are looking outside*, as well as physical activities such as walking, running, cycling, swimming? *Do not* include stationary exercise machines, such as treadmills, rowing machines, etc.

School days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Non-school days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Please describe the type of movement your child typically experiences:

On a typical day (over the last three months), how much time does your child spend on physical activities or exercise, such as sports, walking, running, cycling, swimming, playground time? You *can* include stationary exercise machines, such as treadmills, rowing machines, etc.

School days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Non-school days

- < 1 hour
- 1 – 2 hours
- 2 – 4 hours
- > 4 hours

Please describe the type of activities your child typically takes part in:

The following questions are about the time your child spends *outside of school*.

On a typical day (over the last three months), what is your child's sleeping routine?

School days	Non-school days
Sleep start time: _____	Sleep start time: _____
Sleep end time: _____	Sleep end time: _____

Feel free to add further detail, such as regularity or disruption:

Is there anything else you would like to add, relating to your child's eyes or health?

Thank you for taking the time to complete this questionnaire.