NATIONAL EYE INSTITUTE
REFRACTIVE ERROR QUALITY OF LIFE INSTRUMENT—42
(NEI RQL-42)

(SELF-ADMINISTERED FORMAT)

August 2001; Version 1.0

RAND hereby grants permission to use the "National Eye Institute Refractive Error Quality of Life Instrument--42 (NEI RQL-42) in accordance with the following conditions which shall be assumed by all to have been agreed to as a consequence of accepting and using this document:

1. Although we do not recommend it, changes to the NEI RQL-42 may be made without the written permission of RAND. However, all such changes shall be clearly identified as having been made by the recipient.

2. The user of this NEI RQL-42 accepts full responsibility, and agrees to hold RAND harmless, for the accuracy of any translations of the NEI RQL-42 into another language and for any errors, omissions, misinterpretations, or consequences thereof.

3. The user of this NEI RQL-42 accepts full responsibility, and agrees to hold RAND harmless, for any consequences resulting from the use of the NEI RQL-42.

4. The user of the NEI RQL-42 will provide a credit line when printing and distributing this document or in publications of results or analyses based on this instrument acknowledging that it was developed at RAND under the sponsorship of the National Eye Institute. The user will also cite the appropriate development papers. Check the RAND web site (www.rand.org/health/surveysnav.html) for updates and recommended citations.

5. No further written permission is needed for use of the NEI RQL-42.

8/3/01

INSTRUCTIONS:

The following is a survey with statements about problems that involve your vision or feelings that you have about your vision correction. After each question please choose the response that best describes your situation.

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 correction and how it affects your life, your answers must be as accurate as possible.

1. We would like you to fill in the answers to these questions by yourself, if possible.

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

3. Answer the questions by marking the box corresponding to your response.

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.

STATEMENT OF CONFIDENTIALITY:

All information that would permit identification of any person who completed this questionnaire will be regarded as strictly confidential. Such information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without prior consent, except as required by law.

NATIONAL EYE INSTITUTE
42-ITEM REFRACTIVE ERROR QUALITY OF LIFE INSTRUMENT

Date of Completion: ☐☐ ☐☐ ☐☐☐☐

1. If you had perfect vision without glasses, contact lenses, or any other type of vision correction, how different would your life be?

(Mark an X in the one box that best describes your answer.)

No difference ..... 1 ☐
Small difference for the better..... 2 ☐
Large difference for the better ..... 3 ☐
I have this already..... 4 ☐

The following questions are about the effect of your vision on your activities.

When you answer the questions, think about the vision correction you normally use for each activity, including glasses, contact lenses, a magnifier, or nothing at all.

2. How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, fixing things around the house, sewing, using hand tools, or working with a computer?

(Mark One)

No difficulty at all..... 1 ☐
A little difficulty..... 2 ☐
Moderate difficulty..... 3 ☐
A lot of difficulty..... 4 ☐
Never try to do these activities because of vision..... 5 ☐
Never do these activities for other reasons..... 6 ☐

3. How much difficulty do you have seeing because of changes in the clarity of your vision over the course of the day?

(Mark One)

- Don't have changes in the clarity of my vision ..... 1 ☐
- No difficulty at all ..... 2 ☐
- A little difficulty ..... 3 ☐
- Moderate difficulty ..... 4 ☐
- A lot of difficulty ..... 5 ☐

4. How much difficulty do you have judging distances, like walking downstairs or parking a car?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐

5. How much difficulty do you have seeing things off to the side, like cars coming out of driveways or side streets or people coming out of doorways?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐

6. How much difficulty do you have getting used to the dark when you move from a lighted area into a dark place, like walking into a dark movie theater?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐

7. How much difficulty do you have reading ordinary print in newspapers?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐
- Never try to do this because of vision ..... 5 ☐

8. How much difficulty do you have reading the small print in a telephone book, on a medicine bottle, or on legal forms?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐
- Never try to do this because of vision ..... 5 ☐

9. How much difficulty do you have driving at night?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐
- Never drive at night because of vision ..... 5 ☐
- Never do this for other reasons ..... 6 ☐

10. 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?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐
- Never drive in these conditions because of vision ..... 5 ☐
- Never do this for other reasons ..... 6 ☐

11. Because of your eyesight, how much difficulty do you have with your daily activities?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐

12. Because of your eyesight, how much difficulty do you have taking part in active sports or other outdoor activities that you enjoy (like hiking, swimming, aerobics, team sports, or jogging)?

(Mark One)

- No difficulty at all ..... 1 ☐
- A little difficulty ..... 2 ☐
- Moderate difficulty ..... 3 ☐
- A lot of difficulty ..... 4 ☐
- Never try to do these activities because of vision ..... 5 ☐
- Never do these activities for other reasons ..... 6 ☐

QUESTIONS ABOUT YOUR VISION

13. Do you need to wear glasses or bi-focal lenses or use a magnifier when you are reading something brief, like directions, a menu, or a recipe?

(Mark One)

Yes, all of the time ..... 1 ☐
Yes, some of the time ..... 2 ☐
No..... 3 ☐

14. Do you need to wear glasses or bi-focal lenses or use a magnifier when you are reading something long, like a book, a magazine article, or the newspaper?

(Mark One)

Yes, all of the time ..... 1 ☐
Yes, some of the time ..... 2 ☐
No..... 3 ☐

15. When driving at night, do you need to wear glasses or contacts?

(Mark One)

Yes, all of the time ..... 1 ☐
Yes, some of the time ..... 2 ☐
No..... 3 ☐
Don't drive at night because of vision.... 4 ☐
Don't drive at night for other reasons ..... 5 ☐

16. At dusk, when it is just starting to get dark, do you need to wear glasses or contacts for driving?

(Mark One)

Yes, all of the time ..... 1 ☐
Yes, some of the time ..... 2 ☐
No..... 3 ☐
Don't drive at dusk because of vision.... 4 ☐
Don't drive at dusk for other reasons ..... 5 ☐

When you answer these questions, think about the vision correction you normally use, including glasses, contact lenses, a magnifier or nothing at all.

17. How often when you are around bright lights at night do you see starbursts or halos that bother you or make it difficult to see?

(Mark One)

- All of the time ..... 1 ☐
- Most of the time ..... 2 ☐
- Some of the time ..... 3 ☐
- A little of the time ..... 4 ☐
- None of the time ..... 5 ☐

18. How often do you experience pain or discomfort in and around your eyes (for example, burning, itching, or aching)?

(Mark One)

- All of the time ..... 1 ☐
- Most of the time ..... 2 ☐
- Some of the time ..... 3 ☐
- A little of the time ..... 4 ☐
- None of the time ..... 5 ☐

19. How much does dryness in your eyes bother you?

(Mark One)

- Don't have dryness..... 1 ☐
- Not at all..... 2 ☐
- Very little ..... 3 ☐
- Moderately ..... 4 ☐
- Quite a bit..... 5 ☐
- A lot..... 6 ☐

20. How often are you bothered by changes in the clarity of your vision over the course of the day?

(Mark One)

- Never ..... 1 ☐
- Rarely..... 2 ☐
- Occasionally..... 3 ☐
- Sometimes..... 4 ☐
- All of the time ..... 5 ☐

21. How often do you worry about your eyesight or vision?

(Mark One)

- Never ..... 1 ☐
- Rarely..... 2 ☐
- Occasionally..... 3 ☐
- Sometimes..... 4 ☐
- All of the time ..... 5 ☐

22. How often do you notice or think about your eyesight or vision?

(Mark One)

- Never ..... 1 ☐
- Rarely..... 2 ☐
- Occasionally..... 3 ☐
- Sometimes..... 4 ☐
- All of the time ..... 5 ☐

YOUR VISION CORRECTION

When you answer these questions, think about the vision correction that you normally use, including glasses, contact lenses, a magnifier, surgery, or nothing at all.

23. At this time, how clear is your vision using the correction you normally use, including glasses, contact lenses, a magnifier, surgery, or nothing at all?

(Mark One)

- Perfectly clear ..... 1 ☐
- Pretty clear ..... 2 ☐
- Somewhat clear ..... 3 ☐
- Not clear at all ..... 4 ☐

24. How much pain or discomfort do you have in and around your eyes (for example, burning, itching, or aching)?

(Mark One)

- None ..... 1 ☐
- Mild ..... 2 ☐
- Moderate ..... 3 ☐
- Severe ..... 4 ☐
- Very severe ..... 5 ☐

25. How often do you have headaches that you think are related to your vision or vision correction?

(Mark One)

- Never ..... 1 ☐
- Rarely ..... 2 ☐
- Occasionally ..... 3 ☐
- Sometimes ..... 4 ☐
- All of the time ..... 5 ☐

26. How satisfied are you with the glasses, contact lenses, magnifier, or other type of correction (including surgery) you have?

(Mark One)

- Completely satisfied ..... 1 ☐
- Very satisfied ..... 2 ☐
- Somewhat satisfied ..... 3 ☐
- Somewhat dissatisfied ..... 4 ☐
- Very dissatisfied ..... 5 ☐
- Completely dissatisfied ..... 6 ☐

27. In terms of your appearance, how satisfied are you with the glasses, contact lenses, magnifier, or other type of correction (including surgery) you have?

(Mark One)

- Completely satisfied ..... 1 ☐
- Very satisfied ..... 2 ☐
- Somewhat satisfied ..... 3 ☐
- Somewhat dissatisfied ..... 4 ☐
- Very dissatisfied ..... 5 ☐
- Completely dissatisfied ..... 6 ☐

28. If you had perfect vision without glasses, contacts, or any other type of vision correction, how much do you think your life would change?

(Mark One)

- No change ..... 1 ☐
- Small change for the better ..... 2 ☐
- Large change for the better ..... 3 ☐
- I have this already ..... 4 ☐

29. In terms of your appearance, is the type of vision correction you have now the best you have ever had?

(Mark One)

Yes ..... 1 ☐
No ..... 2 ☐

30. In terms of your appearance, is there a type of vision correction that is better than what you have now?

(Mark One)

Yes ..... 1 ☐
No ..... 2 ☐

31. How often did you use a type of correction or treatment that was uncomfortable in the last 4 weeks because it made you look better?

(Mark One)

All of the time ..... 1 ☐
Most of the time ..... 2 ☐
Some of the time ..... 3 ☐
A little of the time ..... 4 ☐
None of the time ..... 5 ☐

32. How often did you use a type of correction that did not correct your vision as well as another correction would have in the last 4 weeks because it made you look better?

(Mark One)

All of the time ..... 1 ☐
Most of the time ..... 2 ☐
Some of the time ..... 3 ☐
A little of the time ..... 4 ☐
None of the time ..... 5 ☐

33. Because of your vision, do you take part less than you would like in active sports or other outdoor activities (like hiking, swimming, aerobics, team sports, or jogging)?

(Mark One)

Yes ..... 1 ☐
No ..... 2 ☐

34. Are there any recreational or sports activities that you don't do because of your eyesight or the type of vision correction you have?

(Mark One)

Yes, many ..... 1 ☐
Yes, a few ..... 2 ☐
No ..... 3 ☐

35. Are there daily activities that you would like to do, but don't do because of your vision or the type of vision correction you have?

(Mark One)

Yes, many ..... 1 ☐
Yes, a few ..... 2 ☐
No ..... 3 ☐

Have you experienced any of the following problems in the last 4 weeks? If yes, how bothersome has it been? Please respond for problems in either or both eyes.

		Mark One	If yes, how bothersome has it been? ***(Mark One)***
36.	Tearing?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all..... 4 ☐
37.	Distorted vision?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all..... 4 ☐
38.	Glare?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all..... 4 ☐

Have you experienced any of the following problems in the last 4 weeks? If yes, how bothersome has it been? Please respond for problems in either or both eyes.

		Mark One	If yes, how bothersome has it been? ***(Mark One)***
39.	Blurry vision with your eyesight or the type of vision correction you use?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all..... 4 ☐
40.	Trouble seeing?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all..... 4 ☐
41.	Itching in or around your eyes?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all..... 4 ☐

Have you experienced any of the following problems in the last 4 weeks? If yes, how bothersome has it been? Please respond for problems in either or both eyes.

		Mark One	If yes, how bothersome has it been? ***(Mark One)***
42.	Soreness or tiredness in your eyes?	**a.** Yes..... 1 ☐ ® No ..... 2 ☐	**b.** Very ..... 1 ☐ Somewhat..... 2 ☐ A little ..... 3 ☐ Not at all ..... 4 ☐