KERATOCONUS RISK INVESTIGATIVE SURVEY (KRIS)

Thank you for taking the time to complete this **KERATOCONUS RISK INVESTIGATIVE SURVEY (KRIS).**

Please feel free to provide additional details/requests at the end of the survey if you feel that the questions did not adequately cover your specific case.

THANK YOU!

Today's date	
Country	
Province/Region	
City	
Age	
Gender	
Nationality	
Ethnic/Tribal Group	
Home Language	
Religion	
Contact information	

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

1. **Have you heard of the eye condition called Keratoconus?**

Yes	
No	

2. **If yes, how would you rate your knowledge of keratoconus on a scale of 1 (no knowledge) to 5 (excellent knowledge)?**

1	2	3	4	5

3. **Has anyone in your family been diagnosed with Keratoconus?**

Mother	
Father	
Brother/Sister	
Cousin	

4. **Do you live in a country where the climate is mostly hot and sunny or cold?**

Climate	
Hot and sunny climate	
Cold climate	

5. **How would you rate the climate of your country in terms of coldness on a scale of 1 (hardly cold) to 5 (mostly cold)?**

1	2	3	4	5

6. **How would you rate the climate of your country in terms of hotness or sunny on a scale of 1 (hardly hot and sunny) to 5 (mostly hot and sunny)?**

1	2	3	4	5

7. **How many hours, on average <u>per week,</u> do you spend outside in the sunlight?**

HOURS	
Less than 8 hours	
8-24 hours	
>24 hours	

8. **How often do you wear a hat when you go out in the sun?**

Always	
Sometimes	
Never	

9. **Are your parents blood relatives/related to each other (Consanguinity)?**

1st cousins	
2nd cousins	
Distant relatives	
Not related	

10. **Father's highest level of education?**

HIGHEST LEVEL OF EDUCATION	
No Formal Schooling	
Junior/Primary School	
Secondary School	
Tertiary	

11. **Mother's highest level of education?**

HIGHEST LEVEL OF EDUCATION	
No Formal Schooling	
Junior/Primary School	
Secondary School	
Tertiary	

12. **Approximately how many hours/day do you spend using a digital device (cellphone/ laptop/tablet)?**

Hours spent using device	
< 2 hours	
2-5 hours	
5-8 hours	
8-12 hours	
> 12 hours	

13. Tick the foods that you eat at least twice a week?

FOOD	
Fish/Chicken	
Red Meat	
Eggs	
Beans	
Milk	
Rice/Pap/Pasta/Bread	
Spinach	
Fruit	
Almonds/Cashews	

14. Have you ever been told that you have a lack of (deficiency) any of these:

TRACE ELEMENTS/VITAMINS	
Zinc	
Selenium	
Copper	
Vitamin D	
Other:	

15. Do you receive meals at school through the School Feeding Scheme?

Yes	
No	

16. Do you/your family receive any social support grant from the government?

Yes	
No	

SECTION B: CLINICAL PROFILE

17. **How would you rate yourself on the <u>knowledge of the following</u> on a scale of 1 (no knowledge) to 5 (excellent knowledge)?**

Disease	1	2	3	4	5
Eczema (skin rash)					
Hayfever					
Vernal Keratoconjunctivitis (VKC)					
Asthma					
Food allergies					
Pollen/dust allergies					
Animal fur allergies					

18. **Do you have any of the following atopic diseases/allergies?**

ATOPIC DISEASES/ALLERGIES	YES	NO
Eczema (skin rash)		
Hayfever		
Vernal Keratoconjunctivitis (VKC)		
Asthma		
Food allergies		
Pollen/dust allergies		
Animal fur allergies		

19. **How would you rate yourself on the knowledge of the following on a scale of 1 (no knowledge) to 5 (excellent knowledge)?**

Disease	1	2	3	4	5
Down syndrome					
Osteogenesis imperfecta					
Ehlers-Danlos syndrome					
Sleep Apnea					
Leber congenital amaurosis					

20. **Do you have any of the following systemic diseases?**

SYSTEMIC DISEASE	YES	NO
Down syndrome		
Osteogenesis imperfecta		
Ehlers-Danlos syndrome		
Sleep Apnea		
Leber congenital amaurosis		

21. **How would you rate yourself on how often you rub your eyes on a scale of 1 (never) to 5 (very often)?**

1	2	3	4	5

22. **If you rub your eyes often (3 or more on the scale above) do you rub with your:**

Fingertips	
Knuckles	
Base of the thumb	
Palm of the hand	

23. **Which eye do you mostly rub?**

EYE	
Both eyes together	
Right eye	
Left eye	

24. **How do you mostly rub your eyes?**

EYE RUBBING PATTERN	
Through the lids at the centre	
Through the lids at the top of the eyeball	
Underneath the eyeball at the base of the lower lid	
On the bone next to the inner eye	

25. **When sleeping do you mostly sleep on (tick one option):**

SLEEP POSITION	
SUPINE (on your back)	
PRONE (on your stomach)	
On your left side	
On your right side	

26. **How would you rate yourself on knowledge on rigid contact lenses on a scale of 1 (no knowledge) to 5 (excellent knowledge)?**

1	2	3	4	5

27. Do you wear/have you worn rigid contact lenses?

Yes	
No	

28. How would you rate yourself on knowledge of LASIK eye surgery on a scale of 1 (no knowledge) to 5 (excellent knowledge)?

1	2	3	4	5

29. Have you had LASIK eye surgery previously?

Yes	
No	

THANK YOU FOR PARTICIPATING IN THE SURVEY