



All India Ophthalmological Society

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Form 1 : Diabetic Eye Screening Clinic

Question	Answer	
Name of Respondent		Gender: Male =1, Female = 2.
Person Unique ID No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Age	_____ (in complete years)	
Address		
Phone / Email ID		
Date of Examination	(dd / mm /yyyy) ____/____/____	
Duration of Diabetes Since Detection	(in years and months)	
Family History (If yes, put P or S or both in box) Parents / Siblings (P/S)	<input type="checkbox"/> Yes P/S or PS, No 2, Don't know 3	
Are you on any Medication for Diabetes (Insulin : I / Oral : O) (if yes, put I or O in box)	<input type="checkbox"/>	Duration of Medication _____
Nature of Medication	1. Allopathic <input type="checkbox"/> 2. AAYUSH System <input type="checkbox"/> 3. Home remedies <input type="checkbox"/>	
Do you have any other complication Of Diabetes? If yes, please specify.	1. Kidney 2. Heart 3. Stroke 4. Other 5. No Complication.	
Ht/wt details	Height (cm) _____	Weight (Kg) _____
Vitals	Blood Pressure (mmHg)	Blood Sugar (mg/dl) _____ Last Meal Taken _____
Presenting Visual Acuity	Right Eye _____	Left Eye _____
Lens (Cataract :1, Normal :2, Aphakia : 3, Pseudophakia : 4)	<input type="checkbox"/>	<input type="checkbox"/>
Fundus Photograph after dilating pupils (Yes : 1, No : 2)	<input type="checkbox"/>	<input type="checkbox"/>
IOP in mmHg	<input type="checkbox"/>	<input type="checkbox"/>
Presence of Diabetic Retinopathy 0 : No DR, 1. Mild NPDR, 2. Moderate NPDR, 3. Severe NPDR, 4. PDR, 99. Could not be Assessed (CNBA)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Macular Edema Yes : 1, No : 2	<input type="checkbox"/>	<input type="checkbox"/>
Patient Referred to Higher Centre for	1. DR 2. Cataract 3. Others Specify _____	
Other Ocular Disease	Right Eye _____	Left Eye _____
Name / Signature of Ophthalmologist & Date		

I consent to use of the information in this case sheet for research purposes

Signature of patient/thumb impression