Supplemental Appendix 1: Participant questionnaire

Date: _____
Coded subject ID #: _____

Research Questionnaire

1. **How old are you? _____ years**
2. **What is your sex?**
   _____ male
   _____ female
3. **How tall are you now? _____ft _____inches**
4. **How tall were you when you were 18? _____ft _____inches**
5. **How much do you weigh now? _____ pounds**
6. **How much did you weigh when you were 18? _____ pounds**

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7. **What is your race? (check all that apply)**
   _____ White
   _____ Black or African American
   _____ Asian
   _____ American Indian or Alaskan Native
   _____ Native Hawaiian or Other Pacific Islander
   _____ Other (specify: _____)
8. **What is your ethnicity?**
   _____ Hispanic or Latino
   _____ Not Hispanic or Latino

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9. **Did you ever smoke tobacco? YES / NO**
10. **Do you currently smoke tobacco? YES / NO**

If YES to question 9 or 10:

a. **What do/did you smoke?**
   _____ cigarettes
   _____ e-cigarettes
   _____ cigars
   _____ pipe
   _____ other (specify: _____)
b. **How many years have you smoked? _____ years**
c. **How much do/did you smoke (for example: packs per day)? _____**

Petrela RB, *et al. BMJ Open Ophth* 2025; 10:e001884. doi: 10.1136/bmjophth-2024-001884

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11. Do you have high blood pressure? YES / NO

12. Do you have age-related heart disease (for example: heart attack, heart failure, coronary artery disease, stents)? YES / NO

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13. Have you ever been diagnosed with diabetes? YES / NO

If YES to question 13:

a. What type of diabetes do you have?

_____ Type 1

_____ Type 2

b. How many years have you had diabetes?
_____ years

c. Do you use insulin to control your diabetes?
YES / NO

d. Have you been diagnosed with neuropathy (tingling or numbness in your hands or feet) due to diabetes? YES / NO

e. Do you have kidney disease due to diabetes?
YES / NO

f. Do you have eye disease due to diabetes?
YES / NO

g. Do you have trouble with your blood circulation due to diabetes? YES / NO

h. Have you had an amputation because of your diabetes? YES / NO

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14. How often do you wear contact lenses?
ALWAYS / SOMETIMES / NEVER

15. How often do you wear glasses?
ALWAYS / SOMETIMES / NEVER

16. How often do you wear contact lenses, glasses or sunglasses outside? ALWAYS / SOMETIMES / NEVER

17. How often do you wear a sun-blocking hat when outside?
ALWAYS / SOMETIMES / NEVER

Date: _____
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18. Do any of your family members have Fuchs corneal dystrophy?
YES / NO

If YES to question 18:

a. List the relationship to you of the family members with Fuchs corneal dystrophy (for example: mother, father, sister, etc)
_____

_____

19. Do any of your family members have macular degeneration?
YES / NO

If YES to question 18:

a. List the relationship to you of the family members with macular degeneration (for example: mother, father, sister, etc)
_____

_____

FEMALES only

20. How old were you when you got your first period? _____ years

21. Have you ever been pregnant? YES / NO

If YES to question 21:

a. How many times have you been pregnant?
_____

b. How many pregnancies were longer than 3 months? _____

c. How old were you when you had your first pregnancy (that was longer than 3 months)?
_____ years

d. Did you breastfeed after pregnancy?
YES / NO

If YES to question 21d:

i. How many total months (all babies combined) did you breastfeed?
_____

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22. Have you ever used oral contraceptives (birth control pills) or other hormonal birth control methods? YES / NO

If YES to question 22:

e. How many years did you use these birth control methods? _____ years

23. Have you reached menopause? YES / NO

If YES to question 23:

a. At what age was your last period? _____ years

b. Did you reach menopause naturally or after surgery?

_____ naturally
_____ surgically with removal of:
_____ uterus (hysterectomy)
_____ ovaries (oophorectomy)

24. Did you ever take hormone replacement therapy? (estrogen and / or progesterone) YES / NO

If YES to question 24:

a. What kind of hormone replacement therapy?

_____ estrogen only
_____ estrogen and progesterone
_____ unknown

b. How long did you use hormone replacement therapy? _____ years