Low Vision Patient Questionnaire

Today's Date: _____
Patient Full Name: _____
Date of Birth:_____

What are your major difficulties you are having due to your vision/What goals do you have?

Is anyone accompanying you to your visit?

Please list the name, relationship of a family member, friend, association you give permission for medical, appointment or accounting information to be shared with.

Name:
Relationship:
Phone number:
Email:

Patient Initial _____ Date:_____
Following is a questionnaire about your health/vision please fill out to the best of your ability. If unable to due do to vision and no one is able to assist you please call and let us know. 508-753-5103

Do you have any of the following Eye Conditions:

Disease	Diagnosis Date/number of years	Current Treatments (Drops, injections, medications, patching as a child etc)
Glaucoma		
Age Related Macular Degeneration		
Diabetic Retinopathy		
Stroke with visual field loss		
Retinitis pigmentosa		
Stargardt's disease		
Albinism/Ocular Albinism		
Nystagmus		
Amblyopia		
Stroke		
Cataract surgery		
Other		

Please list other eye care professionals you see:

Are you Registered with the Massachusetts Commission for the Blind?(Circle)Yes No

Do you know your case workers name and Contact?:

Are you a veteran? (Circle) Yes No

Do you currently receive services from the VA? (Circle) Yes No

Low vision Functional Questions

Which of the following do you have difficulty with?

- ☐ **Reading**
- ☐ **Watching TV**
  - ☐ **What size is the screen? _____ inches**
  - ☐ **How far away if the screen? _____ feet**
- ☐ **Seeing faces**
- ☐ **Navigation of familiar places or unfamiliar places**
- ☐ **Glare Indoor? Outdoors?**
- ☐ **Other Please List:**

Reading

Prior to vision loss were you an avid reader? (Circle) Yes No

What type of materials do you have difficulty reading? (Check all that apply)

- ☐ **Newspapers**
- ☐ **Mail/Bills**
- ☐ **PriceTags**
- ☐ **Standard-print books**
- ☐ **Large Print Books**
- ☐ **Medicine bottles**
- ☐ **Package directions**
- ☐ **Menus at restaurants**

What lighting conditions help you see the best? (Check all that apply)

- ☐ **Dim light**
- ☐ **Bright overhead lights**
- ☐ **Bright Goose neck lamps**
- ☐ **Bright sunny day**
- ☐ **Overcast day**

Around the house are you having difficulty doing any of the following? (Check all that apply)

- ☐ **Seeing microwave buttons**
- ☐ **Seeing stove buttons**
- ☐ **Burns or cuts in kitchen due to vision**
- ☐ **Seeing food on the plate**
- ☐ **Reading recipes/food prep directions**
- ☐ **Reading nutrition facts**
- ☐ **Seeing laundry buttons**
- ☐ **Seeing thermostat**

Do you use any of the following technologies? CHECK ALL THAT APPLY

- ☐ **iPhone**
- ☐ **Android phone**
- ☐ **Flip phone**
- ☐ **iPad**
- ☐ **Kindle**
- ☐ **Other tablet**
- ☐ **Alexa/google home/Siri**
- ☐ **Mac**
- ☐ **PC Desktop or Laptop**
- ☐ **Audio books (Circle platform: Audible/Libby/BARD/Apple Books/other)**
- ☐ **Other**

Have you enlarged the text size on your device?

- ☐ **Yes**
- ☐ **No, but please show me how (BRING DEVICE TO EXAM IF PORTABLE)**
- ☐ **No, but I do not want to**

What types of low vision devices do you use now or have you tried in the past? (CHECK ALL THAT APPLY)

- ☐ **None**
- ☐ **Hand held magnifier**
- ☐ **Stand magnifier**
- ☐ **High powered reading glasses**
- ☐ **Prism half eyes**
- ☐ **Loupes**
- ☐ **Hand held telescope**
- ☐ **Wearable binocular telescope**
- ☐ **CCTV or video magnifier**
- ☐ **High intensity lamps**
- ☐ **Large print books, magazines, etc.**
- ☐ **Talking books/reading services**
- ☐ **Speech output reading machine**
- ☐ **White long cane/Support white cane**
- ☐ **Guide dog (seeing eye dog)**

<u>Driving</u>

Do you currently drive?

- ☐ **Yes**
- ☐ **No When did you stop?_____**
- ☐ **Day time only**
- ☐ **Bioptic**

Do you limit your driving in any way?

- ☐ **Daytime Only**
- ☐ **Familiar areas only Low Traffic Roads**
- ☐ **Not in bright sunlight**
- ☐ **Do you drive at night?**
- ☐ **Rural roads only**
- ☐ **Geographic/certain routes No highways/interstates**
- ☐ **Not in bad weather**

How would you rate the quality of your driving? (Circle) Poor Good Excellent

What are your current sources of transportation? (check all that apply)

- ☐ **Self**
- ☐ **Family/Friends**
- ☐ **Public Transportation**
- ☐ **Taxi/Uber/other chauffeur service**
- ☐ **Special transportation**
- ☐ **Council on Aging**
- ☐ **Lions Club**
- ☐ **Other _____**

Other

Do you have any hobbies? Please list

Are you currently employed? **And What is/was your Occupation?**

- ☐ **No**
- ☐ **Yes Full Time**
- ☐ **Yes Part Time**
- ☐ **Retired**

Anything else you would like to share with the doctor?