LOW VISION PATIENT QUESTIONNAIRE

Date: ____/____/_____

LAST NAME: _____FIRST NAME:_____MI___
ADDRESS: _____
CITY:_____ ZIP:_____
PRIMARY PHONE # _____ALT PHONE #_____
MEDICARE NUMBER:_____DOB_____AGE_____
OCCUPATION:_____
EMPLOYER or SCHOOL:_____
WHO REFERRED YOU?: _____
HOBBIES (SPORTS): _____
E-MAIL:_____
EMERGENCY CONTACT NAME: _____ PHONE #: _____
RELATIONSHIP TO YOU:_____

Rev 0721

WHAT ARE THE REASONS FOR TODAY'S VISIT (check all that apply)?

- ❑ Annual eye exam
- ❑ Distance blur
- ❑ Near/Reading blur
- ❑ Double vision ❑ Headaches
- ❑ Problems with Computer use
- ❑ Lost or broken glasses
- ❑ Not effective glasses
- ❑ Never worn glasses
- ❑ Learning difficulties
- ❑ Brain Injury
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Light sensitive
- ❑ Neurological problem
- ❑ Low vision; (cause) _____
- ❑ Other _____

EYE HEALTH	Self:	Other Family:
❑ Eye Disease or Injury	❑	❑_____
❑ Eye Surgery	❑	❑_____
❑ Glaucoma	❑	❑_____
❑ Cataracts	❑	❑_____
❑ Macular Degeneration	❑	❑_____
❑ Retinal Degeneration	❑	❑_____
❑ Crossed Eye	❑	❑_____
❑ Lazy Eye	❑	❑_____
❑ Other	❑	❑_____

Brief history of Eye Health _____
_____
Date of last eye exam: _____ Name of eye doctor(s):_____
Age of present glasses: _____ years
Contact Lens wearer: ❑ Y ❑ N If yes, type:_____

MEDICAL HISTORY

DO YOU OR ANY RELATIVES HAVE ANY OF THE FOLLOWING? (check and indicate who has the condition)

	Self:	Other Family:
❑ Diabetes	❑	❑_____
❑ High Blood Pressure	❑	❑_____
❑ Arthritis	❑	❑_____
❑ Thyroid problems	❑	❑_____
❑ Lung Disease	❑	❑_____
❑ Heart Disease	❑	❑_____
❑ Gastrointestinal	❑	❑_____
❑ Ears/nose/throat	❑	❑_____
❑ Mental	❑	❑_____
❑ Immune	❑	❑_____
❑ Other	❑	❑_____

MEDICATIONS : List any you are now taking

❑ I will provide a list

_____

_____

_____

ALLERGIES:

❑ No known drug allergies

_____

Have you had any surgical operations: ❑ Y ❑ N If yes, describe when and type:

_____

_____

Name of Primary Doctor: _____Date of Last Visit: _____

Women: Are you pregnant or nursing? ❑ Y ❑ N

Do you use: Cigarettes? ❑ Y ❑ N Alcohol? ❑ Y ❑ N Other substances? ❑ Y ❑ N

LIFESTYLE QUESTIONS

*Grade level of difficulty: **0**- None or N/A, **1**-Minimal, **2**-Moderate, **3**-Maximum*

Media
TV: _____
Computer: _____ Desktop? _____ Laptop? _____ Typing? _____

What are you using your computer mainly for?
_____

Personal Care/ Health Care
Make-up_____ Nail Care ____ Shaving____
Showering _____ ID of meds ____ Administration of medication _____

Eating
Locating food _____ Eating in restaurants _____

Meal preparation
Pouring liquids ____ Cutting/slicing ____ Microwave use _____
Use of oven/stove ____ Measuring food ____

Financial Management
Organization of money ____ Paying bills ____ Writing checks _____

Functional Communication
Reading price tags _____ Books _____ Newspaper _____
Magazine/TV guide _____ Thermostat _____ Writing _____
Phone Dialing _____ Phone Directory _____ Address Book _____

Functional Mobility
Mobility: _____ Stairs: _____ Falling: _____
Street signs: _____ House #'s: _____ Crossing street alone: Y N
Driving: _____

Please describe challenges:

What areas are you having the most difficulty with (mobility, self-care, food preparation, reading…)?

_____

_____

_____

_____

_____

Are you currently receiving support, assistance or other services? Has it been helpful?

_____

_____

_____

Have you used visual aids? What kind? (magnifiers, software/apps, video technology)

_____

_____

_____

Additional goals, comments, questions:

_____

_____

_____

Patient Reviewed and Signed:_____Date:_____
Doctor Reviewed and Signed:_____Date:_____

Patient Reviewed and Signed:_____Date:_____
Doctor Reviewed and Signed:_____Date:_____