Low Vision Patient Questionnaire

Today’s Date: ________________

Patient Name: _______________________________________________________

Date of Birth: ___________________________________________________________________

What are your chief complaints about your vision?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is anyone accompanying you to your visit?  ☐ Yes  ☐ No

Emory Eye Center respects your right to privacy. If you would like to give your permission for medical and/or accounting information to be discussed with a family member or friend, please provide his/her name:

Name: _______________________________________________________________________

Relationship: _________________________  Date: ______________________

Health & Medical History

1. Do you have any difficulty hearing?  ☐ Yes  ☐ No

2. Do you use a hearing aid?  ☐ Yes  ☐ No

3. Do you use American Sign Language?  ☐ Yes  ☐ No
4. Have you ever had a stroke? □ Yes □ No

5. What types of problems have you had as a result of the stroke?
   □ Speech limitations
   □ Hearing Problems
   □ Weakness
   □ Decreased sensation
   □ Decreased cognition (memory, attention)
   □ Decreased vision
   □ Partial paralysis
   □ Decreased coordination
   □ Decreased balance
   □ None

6. Do you take any eye drops? □ Yes □ No

Daily Living

1. What best describes your present living arrangements?
   □ Live alone
   □ With spouse or other companion
   □ With adult children
   □ With young children
   □ With siblings/parents/or other guardian

2. Do you live in a/an:
   □ House
   □ Apartment/Condo/Townhome
   □ Nursing Home
   □ Retirement Community
   □ Independent Living Community
   □ Other ________________________________
3. What support services provide you with assistance now?
   □ None
   □ Family members
   □ Friends
   □ Community sponsored services
   □ Church groups or service organizations (i.e. Lion’s Club)
   □ School
   □ Vocational rehabilitation/other government agency
   □ Home healthcare services
   □ Support groups
   □ Hospital or other private agency sponsored services

4. Do you have any of the following responsibilities? (check all that apply)
   □ Housekeeping
   □ Cooking
   □ Laundry
   □ Shopping
   □ Managing personal or family finances
   □ Care for spouse or other adult
   □ Care for children
   □ Home repairs/maintenance
   □ Other ____________________________________________
   □ At the present time, I do not manage any responsibilities

5. How difficult is it for you to perform everyday activities? (example: managing finances, housekeeping, using the telephone, watching TV)
   □ Not difficult          □ Very difficult
   □ Mildly difficult       □ Impossible to do
   □ Moderately difficult

6. Do other physical disabilities limit you in your ability to perform everyday activities? □ Yes □ No
   If yes, how much physical disabilities limit your ability to perform daily activities?
   □ Moderately difficult □ Considerably difficult □ Impossible

7. Have you had rehabilitation/outpatient/home health in the past?
Education/Work

1. Level of formal education:
   □ None
   □ Grade 6 or less
   □ Some high school
   □ High school graduate
   □ Some college or technical school
   □ College or technical school graduate
   □ Some postgraduate study
   □ Professional or advanced graduate degree

2. Are your retired?    □ Yes   □ No

3. Are you receiving disability?    □ Yes   □ No

4. Are you currently employed?    □ Yes   □ No
   □ Full Time   □ Part Time
   If yes, what is your occupation? __________________________

5. Has your employer made accommodation for you visual impairment? (i.e. large computer screen)
   □ Yes, full time   □ No   □ Not applicable

6. Are you seeking employment?    □ Yes   □ No

Driving

1. Are you licensed to drive?    □ Yes   □ No

2. Do you currently drive?    □ Yes   □ No
   If you do not drive, when did you last drive? __________________________

3. If you do drive, do you limit your driving in any way?    □ Yes   □ No
4. Do you drive at night? □ Yes □ No

5. Any crashes or near misses over the last 2 years? □ Yes □ No

6. How would you rate the quality of your driving?
□ Excellent □ Very Good □ Good □ Fair □ Poor

7. What are your current sources of transportation? (check all that apply)
□ Drive self
□ Family/Friends
□ Public Transportation
□ Taxi/Uber/other chauffer service
□ Special transportation
□ Other _________________________________

8. Can you walk to public transportation from your home? □ Yes □ No
If so, do you? □ Yes □ No

Vision

1. Have you ever had a low vision exam? □ Yes □ No
If so, when: ______________________________

2. At what age did you develop significant problems with your vision?
□ Birth to 5 years □ 41 to 60 years
□ 6 to 18 years □ Older than 60 years
□ 19 to 40 years

3. Do you have difficulty reading? □ Yes □ No

4. If applicable, when did you start having problems reading?
5. What type of materials do you have difficulty reading? (check all that apply)
- Newspapers
- Large print books
- Mail/Bills
- Medicine bottles
- Price Tags
- Package directions
- Standard-print books

6. Do you use magnifiers to assist your reading?  □ Yes  □ No

7. Do lighting conditions improve how well you can do everyday activities?
   □ Major Effect  □ Moderate  □ No effect

8. Does your vision give you difficulty with recognizing people?
   □ Not difficult  □ Moderately Difficult  □ Very Difficult  □ Impossible

9. Do you have any difficulties seeing the television?  □ Yes  □ No
   - What size is the screen?  ________ inches
   - How far away if the screen?  ________ feet

10. Does your vision give you difficulty getting around by yourself?
    □ Not difficult  □ Moderately Difficult  □ Very Difficult  □ Impossible

11. Because of your vision, how difficult is it for you to take care of your medical concerns?
    □ Not difficult  □ Moderately Difficult  □ Very Difficult  □ Impossible

12. Because of your vision, how difficult is it for you to take care of your personal hygiene?
    □ Not difficult  □ Moderately Difficult  □ Very Difficult  □ Impossible

13. Can you perform basic self-care (grooming, bathing, dressing)?  □ Yes  □ No

14. Can you manage your finances (fill out forms, pay bills, etc.)?  □ Yes  □ No
15. Can you perform basic home management (fixing lunch, cleaning)?
   □ Yes       □ No

16. Over the past year, do you feel that your vision has?
   □ Gotten worse □ Remained the same □ Improved

17. Does your vision fluctuate? □ Yes       □ No

18. What vision-related rehabilitation services have you had? (check all that apply)
   □ None
   □ Training in the use of low vision devices
   □ Orientation and mobility training
   □ Everyday living skills (personal hygiene, home management)
   □ Vocational rehabilitation
   □ Psychological rehabilitation
   □ Eccentric view training
   □ Social work
   □ Blindness skills training
   □ Other: _____________________________________________________

19. Have you participated in a support group for vision problems?
   □ Yes       □ No

20. Are you receiving psychological counseling by a therapist?
   □ Yes       □ No

21. What types of low vision devices do you use now or have you tried in the past? (check all that apply)

<table>
<thead>
<tr>
<th>Device</th>
<th>Use Now</th>
<th>Tried in the Past</th>
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</thead>
<tbody>
<tr>
<td>None</td>
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<td></td>
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<tr>
<td>Hand-Held Magnifier</td>
<td></td>
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<tr>
<td>Stand Magnifier</td>
<td></td>
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<tr>
<td>Prism half-eyes</td>
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<tr>
<td>Device continued</td>
<td>Use Now</td>
<td>Tried in the Past</td>
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<tr>
<td>High power bifocals</td>
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<tr>
<td>Hyperoculars/very strong glasses</td>
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<tr>
<td>Loupes</td>
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<tr>
<td>Hand-Held telescope</td>
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<tr>
<td>Head-worn telescope/binoculars</td>
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<tr>
<td>Telescope mounted in glasses</td>
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<tr>
<td>CCTV or video magnifier</td>
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<tr>
<td>High intensity lamps</td>
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<tr>
<td>Dark glasses</td>
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<tr>
<td>Glasses with color tint</td>
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<tr>
<td>Talking books/reading services</td>
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<tr>
<td>Speech output reading machine</td>
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<tr>
<td>Large print computer system</td>
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<tr>
<td>Large print books, magazines, etc.</td>
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<tr>
<td>White support cane</td>
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<tr>
<td>White long cane</td>
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<tr>
<td>Other mobility aid</td>
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<tr>
<td>Guide Dog (seeing eye)</td>
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<tr>
<td>Other:_______________________</td>
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**Physical State**
1. Do any of the following mobility limitations apply to you? (check all that apply)  □ None
   □ Use support cane  □ Use battery-operated scooter
   □ Use crutches  □ Require assistance walking
   □ Use walker  □ Use support rail
   □ Use wheelchair  □ bedridden

2. Do you have any hand problems? (check all that apply)
   □ None  □ Can only use one hand
   □ Hand shakes  □ Numbness/tingling
   □ Missing fingers  □ Difficult handling small objects

3. Do you have motion limitations? (check all that apply)
4. What is the best description of your memory?
   - No problems
   - Occasional period of forgetfulness
   - Frequently forgetful
   - Confused

5. How would you describe your current emotional state?
   - Well adjusted
   - Depressed
   - Difficulty coping
   - Anxious
   - Angry
   - Frightened
   - Frustrated
   - Sad

Medical History

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Yes</th>
<th>No</th>
<th>Year of Diagnosis</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Arthritis</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Cancer (please specify)</td>
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<tr>
<td>Diabetes</td>
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<td>Heart Disease</td>
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<td>Hypertension</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Skin Disease</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Neurologic Disorder</td>
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Surgery or Hospitalization
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<th>Surgery/Hospitalization</th>
<th>Year</th>
<th>Details</th>
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**CURRENT MEDICATIONS**

☐ No current medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Amount Per Day</th>
<th>Reason</th>
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<tbody>
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**ALLERGIES**

☐ No known allergies

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reaction</th>
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**SOCIAL HISTORY**

Smoke: ☐ Former smoker ☐ Never smoker ☐ Yes; frequency? _______________

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Family History of Illness/Disease</th>
<th>Details</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ocular Disease</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Other (please explain)</td>
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**REVIEW OF SYSTEMS**
Please indicate yes or no as deemed appropriate regarding the following symptoms. If you are not sure, please leave blank

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>Eyes</th>
<th>Comment</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Blurred vision</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Change in vision</td>
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<tr>
<td></td>
<td></td>
<td>Eye pain</td>
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</tbody>
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**Constitutional/Symptoms**

|    |     | Change in weight              |         |
|    |     | Change in activity level      |         |
|    |     | Change in general health      |         |

**Ear, Nose, Throat & Mouth**

|    |     | Hearing problem               |         |
|    |     | Throat soreness               |         |
|    |     | Nasal drainage                |         |

**Cardiovascular**

|    |     | Chest pain                    |         |
|    |     | Irregular heart beat          |         |

**Respiratory**

|    |     | Shortness of breath          |         |
|    |     | Wheezing                      |         |

**Gastrointestinal (G.I.)**

|    |     | Abdominal pain               |         |
|    |     | Diarrhea                      |         |
|    |     | Constipation                  |         |
|    |     | Vomiting                      |         |

**Genitourinary (G.U.)**

|    |     | Pain or difficulty with urination |         |
|    |     | Blood or discoloration in urine |         |

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>Musculoskeletal</th>
<th>Comment</th>
</tr>
</thead>
</table>

Joint Pain or swelling  ______________________________________
Muscle pain or weakness  ______________________________________

Integumentary (Skin)
Rash  ______________________________________
Itching  ______________________________________

Neurological
Headache  ______________________________________
Dizziness  ______________________________________
Weakness or gait disturbance  ______________________________________
Numbness or tingling  ______________________________________

Psychiatric
Anxiety  ______________________________________
Depression  ______________________________________
Emotional changes  ______________________________________
Inconsolable  ______________________________________

Endocrine
Change in sleep or eating  ______________________________________
Cold or heat intolerance  ______________________________________
Abnormal growth/development  ______________________________________

Hematologic/ Lymphatic
Frequent bruising or bleeding  ______________________________________
Frequent infections  ______________________________________

Allergic/ Immunologic
Environmental or food allergies  ______________________________________

Thank you for taking time to complete this form. It will be helpful to us in providing you with the best care possible.

- Your Vision Rehabilitation Team