Name_____

VISTA CENTER LOW VISION CLINIC
PRE-VISIT EVALUATION QUESTIONNAIRE

Please complete and bring with you to your Low Vision Evaluation appointment.

EYE CONDITION:

1. **When did you last see your eye doctor? _____**
   Was it your ophthalmologist or optometrist? (circle one)
2. **Are you scheduled for another appointment? Is so, when?**
   _____
3. **What is your eye condition (e.g., macular degeneration, glaucoma, retinitis pigmentosa, Stargardt's, nystagmus, etc.)?**
   _____
   a. **When was your eye condition first diagnosed? _____**
   b. **Have you had eye surgery? Yes / No**
      If so, what type? _____
   c. **Have you had any laser eye treatments? Yes / No**
      If so, when and for which eye(s)? _____
   d. **Are you now being or have you in the past been treated for your eye disease? Yes / No**
      If so, what is or has been the treatment? _____
      _____
4. **Do you ever see objects, shapes, or people in your vision that you know are not real? Yes / No**

GENERAL HEALTH:

5. **What is your family's medical history (e.g., cancer, diabetes, etc.) and please indicate who has it (e.g., mother, brother, etc.)**
   _____
   _____
6. **How is your general health?_____**
   _____

Name_____

7. Do you smoke? Never / Not anymore / Yes
If yes, how many a day? _____

8. Do you take any medications? Yes / No
If so, what medications do you take and for what health conditions? (Please indicate dosage if possible) _____
_____

e. Are you allergic to any medications? Yes / No
If so, what medications? _____

f. Can you manage your medications by yourself? Yes / No

MAGNIFYING AIDS:

9. What type of magnifying devices do you currently use (e.g., magnifiers, telescopes)? _____

10. If you wear glasses, what type are they (e.g., single vision, bifocal, trifocal, PAL)? _____

g. What do you use them for? _____

h. How old is the prescription? _____

SUNGLASSES:

11. Do you wear sunglasses? Yes / No

i. What color are the lenses? _____

j. Are your eyes sensitive to the sun or to glare? Yes / No

Below is a list of tasks that people generally encounter in their daily lives. You will be asked how easy or difficult each one is for you and whether or not the difficulty is due primarily to your vision loss. Please think about whether you would like to be able to do the task better.

READING ABILITY:

12. Can you see well enough to read a magazine article or book? Yes / No
Is it regular or large print? _____

Name_____

13. Can you read information that you have written yourself? Yes / No
14. Can you read a menu or follow a recipe? Yes / No
15. Can you see prices or labels when you go shopping? Yes / No
16. Do you use a computer? Yes / No
k. If so, please answer the following questions:
i. What size is the monitor? _____
ii. How close to the screen do you sit? _____
iii. Do you use any magnification software or computer screen readers? Yes / No

WRITING ABILITY:

17. Can you sign your name legibly on a signature line? Yes / No
18. Can you address an envelope? Yes / No
19. Can you maintain a check register? Yes / No

DAILY LIVING SKILLS:

20. Do you live by yourself, with family, or others? _____
21. Can you see well enough to use a stove, oven, or microwave? Yes / No
22. Can you pour hot liquids? Yes / No
23. Can you measure using common kitchen measuring devices? Yes / No
24. Can you prepare or serve a meal? Yes / No
25. What type of telephone do you use (e.g., rotary, push button, large numbered, cell phone, smart phone, PDA device)? ___ _____
l. Can you see well enough to dial a telephone? Yes / No
m. Do you use any dialing assistive devices? Yes / No
26. What type of watch do you have (e.g., regular, large numbered, talking)? _____
n. Can you see well enough to tell time with a watch or clock? Yes / No

Name_____

27. Do you watch television or DVDs/Videos on your TV? Yes / No

- **o. How close to the TV do you sit? _____**
- **p. What size TV screen do you have? _____**
- **q. How well do you see TV? _____**
- **r. How well do you see remote control devices for your TV, DVD/Video player, etc.? _____**

ORIENTATION AND MOBILITY:

28. Do you use a cane, walker, or wheelchair? Yes / No
29. Do you travel outside your home? Yes / No
30. Do you have difficulty with curbs or stairs? Yes / No
31. What mode of transportation do you use (e.g., still driving, paratransit, bus, train)? _____
32. When crossing the street, can you see street lights and street signs? Yes / No

SOCIAL SKILLS:

33. Do you have any hobbies or recreational activities? Yes / No
Please specify: _____
_____
34. Do you travel or participate in activities outside the home?
_____
35. How has your vision loss affected you emotionally? _____
_____

GOALS:

36. What are your goals for your low vision appointment (e.g., to read, to write, to spot street signs, to use a computer better)?
_____
37. Is there any particular equipment that you would like to have demonstrated (e.g., magnifiers, telescopes, close circuit television)? _____

Name_____

38. Is there anything else you would like to share with your low vision professional to help you develop a low vision aid strategy? _____
_____

EMAIL ADDRESS (optional): _____
[in the event our doctor needs to reach you other than by phone]