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: ________________________
# Medical History

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

## SURGERY OR HOSPITALIZATION

<table>
<thead>
<tr>
<th>Surgery/Hospitalization</th>
<th>Year</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

## CURRENT MEDICATIONS

Please use back of this page if additional space is needed

- No current medications

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

- No known allergies

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reaction</th>
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<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### 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>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
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<tr>
<td>Other (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OCULAR HISTORY

<table>
<thead>
<tr>
<th>Disease/Illness</th>
<th>Diagnosed when (month/year)?</th>
<th>Surgery/Treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macular Degeneration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## REVIEW OF SYSTEMS

Please indicate yes or no as deemed appropriate regarding the following symptoms.

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>Eyes</th>
<th>Comment</th>
</tr>
</thead>
<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>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eye pain</td>
<td></td>
</tr>
</tbody>
</table>

### Constitutional/Symptoms

<table>
<thead>
<tr>
<th>YES</th>
<th>Change in weight</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Change in activity level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Change in general health</td>
<td></td>
</tr>
</tbody>
</table>

### Ear, Nose, Throat & Mouth

<table>
<thead>
<tr>
<th>YES</th>
<th>Hearing problem</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Throat soreness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nasal drainage</td>
<td></td>
</tr>
</tbody>
</table>

### Cardiovascular

<table>
<thead>
<tr>
<th>YES</th>
<th>Chest pain</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Irregular heart beat</td>
<td></td>
</tr>
</tbody>
</table>

### Respiratory

<table>
<thead>
<tr>
<th>YES</th>
<th>Shortness of breath</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wheezing</td>
<td></td>
</tr>
</tbody>
</table>

### Gastrointestinal (G.I.)

<table>
<thead>
<tr>
<th>YES</th>
<th>Abdominal pain</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vomiting</td>
<td></td>
</tr>
</tbody>
</table>

### Genitourinary (G.U.)

<table>
<thead>
<tr>
<th>YES</th>
<th>Pain or difficulty with urination</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood or discoloration in urine</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
<td>Musculoskeletal Comment</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Joint Pain or swelling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Muscle pain or weakness</td>
</tr>
</tbody>
</table>
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

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
   □ Mildly difficult
   □ Moderately difficult
   □ Very difficult
   □ Impossible to do

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

☐ Yes ☐ No
If yes, please describe ________________________________

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 you 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
   If so, how?
   □ Daytime Only  □ Rural roads only
   □ Familiar areas only  □ Geographic/certain routes
   □ Low traffic roads  □ No highways/interstates
   □ Not in bright sunlight  □ Not in bad weather

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  1   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?
   ☐ Less than 6 months ago
   ☐ 6 to 12 months ago
   ☐ 1 to 2 years ago
   ☐ More than 2 years ago

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 is 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 is the best description of your memory?  
- No problems
- Occasional period of forgetfulness
- Frequently forgetful
- Confused

22. How would you describe your current emotional state?  
- Well adjusted
- Depressed
- Difficulty coping
- Anxious
- Angry
- Frightened
- Frustrated
- Sad
23. 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>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
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<tr>
<td>Hand-Held Magnifier</td>
<td></td>
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<tr>
<td>Stand Magnifier</td>
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<tr>
<td>Prism half-eyes</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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<td></td>
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<tr>
<td>CCTV or video magnifier</td>
<td></td>
<td></td>
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<tr>
<td>High intensity lamps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dark glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses with color tint</td>
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<tr>
<td>Talking books/reading services</td>
<td></td>
<td></td>
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<tr>
<td>Speech output reading machine</td>
<td></td>
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<tr>
<td>Large print computer system</td>
<td></td>
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<tr>
<td>Large print books, magazines, etc.</td>
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<td></td>
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<tr>
<td>White support cane</td>
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<td></td>
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<tr>
<td>White long cane</td>
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<tr>
<td>Other mobility aid</td>
<td></td>
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<tr>
<td>Guide Dog (seeing eye)</td>
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<tr>
<td>Other:_________________________</td>
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</tr>
</tbody>
</table>
Physical State

1. Do any of the following mobility limitations apply to you? (check all that apply)  
   - [ ] None
   - [ ] Use support cane
   - [ ] Use crutches
   - [ ] Use walker
   - [ ] Use wheelchair
   - [ ] Use battery-operated scooter
   - [ ] Require assistance walking
   - [ ] Use support rail
   - [ ] bedridden

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

3. Do you have motion limitations? (check all that apply)
   - [ ] None
   - [ ] Head shakes
   - [ ] Limited head/neck movement
   - [ ] Limited arm movement
   - [ ] Limited balance when seated

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

-