EMORY
EYE CENTER

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

Past Medical History	Yes	No	Year of Diagnosis	Details
Arthritis				
Asthma				
Cancer(please specify)				
Diabetes				
Heart Disease				
Hypertension				
Kidney Disease				
Skin Disease				
Stroke				
Neurologic Disorder				

SURGERY OR HOSPITALIZATION

Surgery/ Hospitalization	Year	Details

CURRENT MEDICATIONS

Please use back of this page if additional space is needed

 No current medications

Medication	Amount Per Day	Reason

ALLERGIES

 No known allergies

Allergies	Reaction

SOCIAL HISTORY

Smoke: Former smoker Never smoker Yes; frequency?

_____

FAMILY HISTORY

Family History of Illness/Disease	Details	Relationship
Ocular Disease		
Diabetes		
Heart Disease		
Hypertension		
Other (please explain)		

OCULAR HISTORY

Disease/Illness	Diagnosed when (month/year)?	Surgery/Treatment?
Cataract		
Glaucoma		
Macular Degeneration		
Other (please explain)		

REVIEW OF SYSTEMS

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

NO	YES	Eyes	Comment
☐	☐	Blurred vision	_____
☐	☐	Change in vision	_____
☐	☐	Eye pain	_____
		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	_____

NO	YES	Musculoskeletal	Comment
☐	☐	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	_____

Additional 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

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?

☐ Moderately difficult ☐ Considerably difficult ☐ Impossible

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 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
   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
   ☐ 6 to 18 years
   ☐ 19 to 40 years
   ☐ 41 to 60 years
   ☐ Older than 60 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
   ☐ Mail/Bills
   ☐ Price Tags
   ☐ Standard-print books
   ☐ Large print books
   ☐ Medicine bottles
   ☐ Package directions

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 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	☐ Angry
☐ Depressed	☐ Frightened
☐ Difficulty coping	☐ Frustrated
☐ Anxious	☐ Sad

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

Device	**Use Now**	**Tried in the Past**
None		
Hand-Held Magnifier		
Stand Magnifier		
Prism half-eyes		
High power bifocals		
Hyperoculars/very strong glasses		
Loupes		
Hand-Held telescope		
Head-worn telescope/binoculars		
Telescope mounted in glasses		
CCTV or video magnifier		
High intensity lamps		
Dark glasses		
Glasses with color tint		
Talking books/reading services		
Speech output reading machine		
Large print computer system		
Large print books, magazines, etc.		
White support cane		
White long cane		
Other mobility aid		
Guide Dog (seeing eye)		
Other:_____		

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)

☐	None	☐	Limited arm movement
☐	Head shakes	☐	Limited balance when seated
☐	Limited head/neck movement		

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**

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