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: _____

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
   - ☐ 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 <u>not</u> 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
- ☐ Familiar areas only
- ☐ Low traffic roads
- ☐ Not in bright sunlight
- ☐ Rural roads only
- ☐ Geographic/certain routes
- ☐ No highways/interstates
- ☐ 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☐ 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	☐ 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)

Device	**Use Now**	**Tried in the Past**
None		
Hand-Held Magnifier		
Stand Magnifier		
Prism half-eyes		
Device continued	**Use Now**	**Tried in the Past**

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 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

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

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

☐ 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)		

REVIEW OF SYSTEMS

Please indicate yes or no as deemed appropriate regarding the following symptoms.
If you are not sure, please leave blank

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 _____

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