NORTHERN VIRGINIA DOCTORS OF OPTOMETRY
LOW VISION QUESTIONNAIRE

This questionnaire will help us focus on the areas of your life affected by your vision loss. A family member or a friend may assist you in completing this form. The information that you provide is confidential.

I. PERSONAL INFORMATION

Name:	DOB:
Address:	Phone Number:
Name of your eye doctor and last visit:	
Your eye doctor's phone number:	
Reason for vision impairment:	

II. SOCIAL HISTORY

Do you drive? □ NO □ YES If no, when did you stop driving?
If yes, do you have difficulty when driving? □ NO □ YES If yes, describe
Do you use tobacco products? □ NO □ YES If yes, type / amount / how long:
Do you drink alcohol? □ NO □ YES If yes, type / amount / how long:

III. FAMILY HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)? Please explain:

IV. GENERAL HEALTH

Medical doctor name:	Last exam:		
Doctor's phone number:			
Please list any current medication, including eye drops you are taking			
Do you have any allergies to medications? □ NO □ YES If yes, please list below			
Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)			
Integumentary/Skin: (rashes, eczema, dermatitis)	N	Y	
Neurologic: (headaches, numbness, weakness, seizures)	N	Y	
Ears/Nose/Mouth/Throat: (allergies, hay fever, sinus congestion)	N	Y	
Respiratory: (shortness of breath, asthma, emphysema)	N	Y	
Vascular: (cholesterol, heart disease, high blood pressure)	N	Y	
Gastrointestinal: (diarrhea, constipation)	N	Y	
Bones/Joints/Muscles: (rheumatoid arthritis, joint pain)	N	Y	
Lymphatic: (anemia, bleeding problems)	N	Y	
Endocrine: (thyroid, diabetes)	N	Y	
Psychiatric (depression, anxiety)	N	Y	

V. VISUAL ASSESSMENT

	Use Now	Tried in Past	
Hand-held or stand magnifiers			
Prism half-eyes			
High-power bifocals			
Loupes			
Hand-held telescopes			
Head-worn telescope/binoculars			
Telescope mounted in glasses			
Video magnifier or CCTV			
Glasses with color tint			
High intensity lamps			
Talking books or reading services			
Speech output reading machine			
Enlargement computer software			
Large print books, magazines, etc.			
White cane			
Other mobility aids			
Guide dog (seeing eye)			
Other			

Low Vision Service

1. What vision-related rehabilitation services have you had?

□ Training in the use of low vision aids
□ Activities of daily living training
□ Vocational rehabilitation
□ Blindness skills training
□ Home management skills training
□ Eccentric viewing training
□ None
□ Other _____

Activities of daily living

1. Do you have any of the following responsibilities?

□ Housekeeping
□ Cooking
□ Laundry
□ Shopping
□ Managing finances
□ Care for a spouse/other adult/child
□ Home maintenance/repairs
□ Other _____

2. What are your current sources of transportation?

□ None
□ Drive self on limited basis
□ Public transportation
□ Taxi cabs
□ Ride with family or friends
□ Chauffeur services
□ Special transportation services
□ Other _____

Please indicate all that applies regarding: (while USING glasses or contacts)

General Vision:

□ I have difficulty recognizing people at a distance of 6 feet
□ Lighting conditions affect how well I can do everyday activities
□ My eyes are uncomfortable in bright sunlight
□ I cannot see well in overcast days
□ I cannot see well at dusk
□ My eyes are uncomfortable with bright indoor light, such as in stores and offices
□ I cannot see well in dim lighting, such as dark restaurants or hallways of building
□ I have difficulty with the glare from a computer or television screen
□ I have difficulty adjusting to light going from outside to inside or vice versa

Reading and Writing:

□ It is moderate to very difficult to manage my paperwork, including bills, finances, correspondence and mail
□ It is moderate to very difficult to read and write letters and notes
□ It is moderate to very difficult to use the computer
□ It is moderate to very difficult to enjoy leisure activities such as crosswords, arts and craft, and card games
□ It is moderate to very difficult to use the computer

Kitchen / Cooking:

□ It is moderate to very difficult to cook my food by using the stove, oven or microwave
□ I cannot see the markings of buttons or dials on the microwave, stove, oven or toaster oven, however, I am accustomed to these appliances and can still cook
□ I still cook but have trouble locating the correct spices or ingredients
□ I cannot see the food on my plate and have trouble feeding myself
□ I cannot see the food labels or instructions on food items
□ I have difficulty checking for expired foods in the cupboards and refrigerator
□ Lighting conditions affect how well I can do everyday activities
□ I cannot see well in overcast days
□ I cannot see well at dusk

Around the House:

□ It is moderate to very difficult to use the washer and dryer to clean my clothing
□ In an emergency, I could not use the telephone
□ It is moderate to very difficult to use the thermostat

Personal Care:

□ I have difficulty finding and identifying items in the bathroom
□ I have difficulty matching or coordinating my clothing
□ I have difficulty checking my hands and feet for sores, cuts or bruises
□ I have difficulty seeing the medicine bottle or I cannot see the warning labels

Shopping:

□ I have difficulty finding what I need in shopping stores
□ I have difficulty seeing the price tags or clothing labels
□ I have difficulty reading receipts or signing my name on receipts

Mobility:

□ I feel unsafe stepping in and out of the shower or bathtub
□ I sometimes bump into furniture, doors or edges of counters and tables
□ I sometimes trip over pets such as dogs or cats
□ I sometimes step on things accidentally
□ I have poor depth perception and am cautious with curbs and steps
□ I am cautious walking up and downstairs or need assistance doing so
□ I do not see well using the elevator or escalators
□ I do not see well entering and exiting buildings
□ I do not see well to cross the street safely
□ I do not see well enough to take the bus or subway
□ I do not see signs or road markings well
□ I feel unsafe walking or traveling in unfamiliar areas

Work & Education:

1. Are you retired? □ YES □ NO (If yes, please skip to the Psychosocial section)

2. Are you working? □ NO □ YES, full-time □ YES, part-time
   If yes, please describe your job _____
3. Are you receiving disability? □ YES □ NO

4. Will your employer assist you with making accommodations? □ YES □ NO

5. Are you doing any volunteer work? □ YES □ NO

6. Are you a student? □ NO □ YES, full-time □ YES, part-time

Psychosocial:

1. How would you describe your current emotional state **(as it pertains to your vision)**
   □ well-adjusted □ motivated □ depressed □ sad □ frustrated
   □ difficulty coping □ anxious □ angry □ frightened

2. Have you seen a psychiatrist or received psychological counseling to help you cope with your vision problems? NO / YES: _____

3. Have you seen a psychiatrist or received psychological counseling for reasons other than your vision problems? NO / YES: _____