Johns Hopkins Wilmer Eye Institute
Lions Vision Rehabilitation Service

Patient Name

Birth date

1. Who referred you to the low vision clinic?

☐ Doctor ☐ Family member ☐ Spouse

☐ Friend ☐ Self-referred ☐ Other

1a. Please provide the name of the person that referred you to our clinic:

2. Is anyone accompanying you to your visit? ☐ Yes ☐ No

2a. If yes, please indicate their name(s) and relationship(s)?

4. What county and state do you live in?

Pre-appointment questions
We appreciate your time and effort completing this form. The information provided greatly assists the doctors & staff assess your needs prior to your evaluation. Your responses to these questions may be discussed in more detail at the time of your visit.

GENERAL HEALTH

1. Do you have any of the following medical conditions?

Diabetes	☐ Yes	☐ No
	☐ Type 1 ☐ Type 2 ☐ Insulin	
Heart problems	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
	☐ Osteoarthritis ☐ Rheumatoid	
Seizures	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Memory problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
	Type: Enter type	
Depression / Anxiety	☐ Yes	☐ No

Do you smoke cigarettes? ☐ Yes ☐ Former ☐ No
Do you use chewing tobacco? ☐ Yes ☐ Former ☐ No
Do you use e-cigarettes? ☐ Yes ☐ Former ☐ No

2. List all medications you currently take (or attach):

3. List any allergies to medications

4. Do you have any difficulty hearing? ☐ Yes ☐ No
   Do you use a hearing aid? ☐ Yes ☐ No

5. Have you ever had a stroke? ☐ Yes ☐ No

   5a. More than one stroke? ☐ Yes ☐ No

   5b. Please provide the date(s) of your previous stroke(s):

   5c. What type of problems have you had as a result of the stroke? (Check all that apply.)

   ☐ Speech limitations ☐ Decreased vision
   ☐ Hearing problems ☐ Partial paralysis
   ☐ Decreased coordination ☐ Physical weakness
   ☐ Decreased sensation ☐ Decreased balance
   ☐ Decreased memory ☐ Reading difficulty
   ☐ Walking difficulty ☐ Navigation/orientation
   ☐ All problems resolved ☐ None

   5d. Have you received any therapy since your last stroke?
   ☐ Occupational ☐ Physical ☐ Speech ☐ Vision

6. How would you describe your current emotional state?

(Check all that apply.)

☐ Well-adjusted ☐ Angry ☐ Anxious
☐ Depressed ☐ Frightened ☐ Sad
☐ Difficulty coping ☐ Frustrated

7. Have you participated in a support group for vision problems?

☐ Yes ☐ No

8. Are you receiving psychological counseling by a therapist?

☐ Yes ☐ No

9. What is the best description of your memory?

☐ No problems
☐ Occasional periods of forgetfulness
☐ Frequently forgetful
☐ Confused

EYE HISTORY

1. Do you have any of the following?

Macular degeneration	☐ Yes	☐ No
Other macular problem	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Diabetic retinopathy	☐ Yes	☐ No
Cataracts (presently)	☐ Yes	☐ No
Retinitis pigmentosa	☐ Yes	☐ No
Ocular albinism	☐ Yes	☐ No
Stargardt's maculopathy	☐ Yes	☐ No
Retinal detachment	☐ Yes	☐ No
Optic nerve problem	☐ Yes	☐ No
Corneal problem / dry eye	☐ Yes	☐ No

Other eye condition(s) not listed?

2. Have you had any eye surgeries? ☐ Yes ☐ No

☐ Cataract
Eye?
☐ Right ☐ Left ☐ Both
☐ Glaucoma
☐ Retinal
☐ Corneal
☐ LASIK / PRK

3. Do you take any eye drops? ☐ Yes ☐ No

READING

1. Do you have difficulty reading? ☐ Yes ☐ No

2. How would you categorize your current reading demands?

☐ Avid ☐ Moderate / some ☐ Minimal

3. What type of material(s) do you have difficulty reading? (Check all that apply)

☐ Newspapers
☐ Magazine
☐ Mail / bills
☐ Package directions
☐ Medicine bottle
☐ Price tags
☐ Books
☐ Computer
☐ Cell Phone
☐ Kindle / iPad / Tablet
☐ Other

Computer

1. Do you use a computer?
   - ☐ Yes
   - ☐ No, had to discontinue due to my vision
   - ☐ No, I'm not interested (Skip to next section)

2. Do you have difficulty seeing the computer screen? ☐ Yes ☐ No

   2a. If yes, what type of computer do you use?
   (Check all that apply)
   - ☐ Windows (i.e. Dell, HP, Sony, IBM, etc.)
     - ☐ Laptop ☐ Desktop
   - ☐ Mac (Apple)
     - ☐ Laptop ☐ Desktop

3. Do you have difficulty seeing the computer keyboard? ☐ Yes ☐ No

4. What do you use your computer for?
(Check all that apply)
   - ☐ Email
   - ☐ Social (i.e. Facebook, Skype, etc.)
   - ☐ Internet search
   - ☐ Games
   - ☐ Word processing
   - ☐ Finances and banking
   - ☐ Excel
   - ☐ PowerPoint presentations
   - ☐ Other: _____

5. What accommodations have you made?
(Check all that apply)
   - ☐ None
   - ☐ Magnifying mouse
   - ☐ Enlarge font or text
   - ☐ Specialized software
   - ☐ Large monitor
   - ☐ Speech output
   - ☐ Large print keyboard
   - ☐ Other: _____

Tablet

1. Do you use a tablet?

☐ Yes Type: _____

☐ No

2. What accommodations have you made? (Check all that apply.)

☐ None ☐ High contrast / bold text

☐ Enlarge font or text ☐ Audio accessibility features

Cell Phone

1. Do you have a cell phone?

☐ Yes ☐ No (Skip to next section)

1a. If yes, what type of cell phone do you own?

☐ iPhone

☐ Android (i.e., Samsung, LG)

☐ Basic flip phone

☐ Other: _____

2. Please indicate any accessibility features you are using on your phone

☐ Large text ☐ Camera to zoom or to magnify

☐ High contrast ☐ Read aloud / speech selection

☐ Voice-over ☐ Other Apps because of vision loss?

VISUAL INFORMATION

1. Does your vision give you difficulty with recognizing people?

☐ Not difficult

☐ Moderately difficult

☐ Very difficult

☐ Impossible

2. Do you have difficulty seeing the television? ☐ Yes ☐ No

If yes, what is your screen size (in inches)? _____

If yes, how far away do you sit from the TV (in feet)? _____

2a. Can you read any text on the television screen?

☐ Yes

☐ Closed Captioning / subtitles

☐ Guide Channel

☐ Scrolling Ticker (on the news)

☐ No

GLARE / LIGHT SENSITIVITY

1. Do you have trouble with sunlight bothering your eyes?

☐ Yes ☐ No

2. Is indoor lighting bothersome to you? ☐ Yes ☐ No

If yes, is it too dim or too bright? ☐ Too Dim ☐ Too Bright

3. Do you wear sunglasses?

☐ Yes

☐ Outdoors ☐ Indoors

☐ No

4. Do you have trouble adjusting to different lighting levels?

☐ Yes ☐ No

MOBILITY / BALANCE

1. In the past 3 months, have you used any of the following mobility aids? (Check all that apply.)

☐ none ☐ battery-operated / electric scooter
☐ support cane ☐ human assistance
☐ white cane ☐ wheelchair
☐ crutches ☐ walker / rollator

2. How many falls have you had in the l year?

☐ None ☐ One ☐ Two ☐ Three or more

3. Because of your vision, do you have difficulty judging curbs, steps, stairs, or uneven pavement?

☐ Not difficult ☐ Moderately difficult
☐ Very difficult ☐ Impossible

4. In the past 3 months, have you had any of the following difficulties?

☐ trip miss a step/curb ☐ bump into things ☐ fear of falling

DRIVING

1. Are you licensed to drive? ☐ Yes ☐ No

State: _____ Expiration Year: _____

2. Do you currently drive? ☐ Yes ☐ No

3. If you do <u>not</u> drive, when is the last time you drove?

☐ _____ years ago ☐ Never

3a. If you do <u>not</u> drive, did you stop because of your vision?

☐ Yes ☐ No, for other reasons

4. If you drive, do you limit your driving?

☐ Yes ☐ No

4a. If yes, how do you limit your driving? (Check all that apply)

☐ daytime only ☐ geographic / certain routes
☐ familiar areas only ☐ no highway / interstate driving
☐ low traffic roads ☐ not in bad weather (i.e., rain, snow)
☐ not in bright sunlight ☐ off peak hours

4b. Do you ever drive at night? ☐ Yes ☐ No

5. If you still drive, how confident do you feel when driving?

☐ Very confident ☐ Moderately confident
☐ Somewhat confident ☐ A little confident
☐ Not confident at all

6. Have you had any motor vehicle incidents during the past two years?

☐ None
☐ Near misses / close calls
☐ Accident(s)
☐ Moving violation (i.e. speeding, running a stop sign, etc.)
☐ Other:

DAILY LIVING

1. What best describes your present living arrangements?

☐ Live alone
☐ Lives with someone:
☐ companion ☐ adult children ☐ young children
☐ sibling ☐ parent/guardian ☐ roommate
☐ other

1a. In a(n)?

☐ House ☐ Apartment ☐ Condominium ☐ Townhouse
☐ Retirement community ☐ Independent living
☐ Assisted living ☐ Nursing home
☐ Other

2. What are your current sources of transportation? (Check all that apply)

☐ Drive self ☐ Ride with family or friends
☐ Public transportation ☐ Uber / Lyft / private driver
☐ Taxi cabs ☐ MTA Mobility / County Ride
☐ Other (Describe:)

3. Do you have difficulties with any of the following tasks? (Check all that apply)

Housekeeping

☐ Easy ☐ Difficult ☐ Unable due to vision

Cooking

☐ Easy ☐ Difficult ☐Unable due to vision

Laundry

☐ Easy ☐ Difficult ☐Unable due to vision

Shopping

☐ Easy ☐ Difficult ☐ Unable due to vision

Managing finances

☐ Easy ☐ Difficult ☐ Unable due to vision

Hobbies

☐ Easy ☐ Difficult ☐ Unable due to vision

☐ At the present time, I do not manage any of the responsibilities.

Other:

4. Because of your vision, how difficult is it for you to take care of your medical concerns (i.e., taking medications, checking blood sugar)?

☐ Not difficult ☐ Very difficult
☐ Moderately difficult ☐ Impossible

5. Because of your vision, how difficult is it for you to take care of your personal hygiene (i.e., brushing teeth, viewing reflection, shaving, applying makeup)?

☐ Not difficult ☐ Very difficult
☐ Moderately difficult ☐ Impossible

6. Do other physical disabilities limit you in your ability to perform everyday activities? ☐ Yes ☐ No

6a. If yes, how much do physical disabilities limit your ability to perform everyday activities?

☐ Moderately difficult ☐ Considerably difficult ☐ Impossible

EMPLOYMENT / EDUCATIONAL STATUS

1. Are you receiving any disability benefits for your vision or any other condition? ☐ Yes ☐ No

2. Do you receive social security disability (SSDI)? ☐ Yes ☐ No
If not, have you applied? ☐ Yes ☐ No

3. Do you receive social security income (SSI)? ☐ Yes ☐ No

4. Are you currently employed?

☐ No ☐ Yes, full-time ☐ Yes, part-time

5. If employed, has your employer provided you with any accommodations because of your vision? ☐ Yes ☐ No ☐ Not applicable

6. Are you meeting your employer's job expectations? ☐ Yes ☐ No

7. Are you seeking employment? ☐ Yes ☐ No

8. Are you retired? ☐ Yes ☐ No

9. Present or prior occupation: _____

10. Are you currently a student? ☐ No ☐ Yes, full-time ☐ Yes, part-time

If yes, please provide your grade level: _____

Please provide any education plans your school provides:

☐ Individual Education Plan (IEP) ☐ 504 plan

11. What is your highest level of education?

☐ High School Diploma / GED
☐ College Degree
☐ Graduate Degree
☐ Other (please specify: _____)

12. Are you a Veteran of the U.S. Military? ☐ Yes ☐ No

If yes, do you currently receive any services at the VA Hospital?

☐ Yes ☐ No

VISUALLY ASSISTIVE DEVICES AND SERVICES

1. What types of glasses do you use now or have you tried in the past? (Check all that apply)

- ☐ Lined bifocals
- ☐ No-line bifocals (progressive lenses)
- ☐ Distance only
- ☐ Reading only
- ☐ Computer only
- ☐ Over-the-counter readers

2. What types of low vision aids do you use now, or have you tried in the past? (Check all that apply)

Hand-held magnifiers	☐ Yes	☐ No
Clip-on magnifiers	☐ Yes	☐ No
Telescopes / bioptics / binoculars	☐ Yes	☐ No
CCTV or video magnifier	☐ Yes	☐ No
High intensity task lamps	☐ Yes	☐ No
Flashlight	☐ Yes	☐ No
Special tinted glasses / wrap-around sunglasses	☐ Yes	☐ No
Talking books or reading service	☐ Yes	☐ No
Speech output reading machine	☐ Yes	☐ No
Large print books / magazines	☐ Yes	☐ No
Headmounted technology	☐ Yes	☐ No

3. What vision-related rehabilitation services have you had?
(Check all that apply)

- ☐ None
- ☐ Low vision exam
- ☐ Training in the use of low vision devices
- ☐ Orientation and mobility training
- ☐ Daily living skills / self-care training
- ☐ Vocational rehabilitation
- ☐ Psychological counseling
- ☐ Eccentric viewing (i.e. side–vision use) training
- ☐ Social work
- ☐ Blindness skills training
- ☐ Other (Describe:)

4. Have you worked with Department of Rehabilitation Services (DORS) or another state rehab service?

☐ Yes ☐ No

4a. If yes, please provide your DORS/Rehab Counselor's name:

4b. When is the last time you were in contact with them?

4c. Please indicate any devices and/or services DORS (or your state rehab agency) has provided you in the past.

Thank You