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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Type 1</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Type 2</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Insulin</td>
<td>☐ No</td>
</tr>
<tr>
<td>Heart problems</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Arthritis</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Seizures</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Memory problems</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Cancer</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td><strong>Type:</strong> Enter type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression / Anxiety</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macular degeneration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other macular problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
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<tr>
<td>Diabetic retinopathy</td>
<td></td>
<td></td>
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<tr>
<td>Cataracts (presently)</td>
<td></td>
<td></td>
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<tr>
<td>Retinitis pigmentosa</td>
<td></td>
<td></td>
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<tr>
<td>Ocular albinism</td>
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<td></td>
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<tr>
<td>Stargardt’s maculopathy</td>
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<td></td>
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<tr>
<td>Retinal detachment</td>
<td></td>
<td></td>
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<tr>
<td>Optic nerve problem</td>
<td></td>
<td></td>
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<tr>
<td>Corneal problem / dry eye</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 ☐ Books
   ☐ Magazine ☐ Computer
   ☐ Mail / bills ☐ Cell Phone
   ☐ Package directions ☐ Kindle / iPad / Tablet
   ☐ Medicine bottle ☐ Other
   ☐ Price tags
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

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**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 1 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 not drive, when is the last time you drove?
   - ☐ _ _ _ years ago
   - ☐ Never

3a. If you do not 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)

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