Low Vision Questionnaire

What have your doctors told you is the cause of your visual problems?

Who was your doctor?

When were you first diagnosed?

When was your last eye exam and by whom?

Have you ever had treatment or surgery for your eyes?

If yes, when and which eye?

Have you had recent changes in your vision?

Do you wear glasses now?_____ If so, do they help?

What bothers you the most about your vision?

What are your main goals you want us to help you accomplish?

Please circle Yes or No for each question.

Can you read newspaper print?	Yes	No
Do you use magnifiers?	Yes	No
Can you watch television?	Yes	No
Do you still drive?	Yes	No
Does sunlight bother your eyes?	Yes	No
Do you wear sunglasses?	Yes	No

Check any of the following activities that your vision causes you to have problems with.

Reading
- Books_____
- Magazines_____
- Newspapers_____
- Large Print_____
- Music_____
- Other_____

Writing
- Letters_____
- Checks_____
- Signing_____
- Other_____

Medical
- Labels_____
- Syringes_____
- Thermometers_____
- Other_____

Personal
- Grooming_____

Household
- Shopping_____
- Dials_____
- Clocks_____
- Watches_____
- Eating_____
- Cooking_____
- Sewing_____
- Laundry_____
- Cleaning_____

Leisure
- Movies_____
- Theater_____
- Television_____
- Radio_____
- Sports_____
- Games_____
- Cards_____
- Computer_____
- Other_____