Date:_____ Start Time:_____

Name:_____ Date of Birth _____

Address:_____ City:_____ State:_____ Zip:_____

Referred by:_____ Phone Number:_____

Do you wish for us to send a report to your eye doctor? Y N Eye Doctor:_____

Have you had previous low vision care? Y N If yes, when and where: _____

If No, do you understand why you have been referred/coming in for the low vision exam? Y N

Have you had previous low vision devices? Y N If yes, From whom if different from above:_____

Reported Diagnoses:

PLEASE CIRCLE ONE:

_____ _____ Right eye Left eye Both

_____ _____ Right eye Left eye Both

_____ _____ Right eye Left eye Both

_____ _____ Right eye Left eye Both

OCULAR HISTORY:

Surgeries, Laser, or other eye treatments:

Date	Doctor	Surgery/treatment	Eye
_____	_____	_____	Right eye Left eye Both
_____	_____	_____	Right eye Left eye Both
_____	_____	_____	Right eye Left eye Both
_____	_____	_____	Right eye Left eye Both

Eye Medications and Vitamins:

Date	Medication Name	How often	Eye	Reason Prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

GENERAL HEALTH HISTORY:

(please list medications and vitamins next to diagnosis conditions)

Diabetes: _____ Date Diagnosed_____

Hypertension (High Blood Pressure): _____

Heart Disease: _____

Arthritis: _____

Parkinson's: _____

Thyroid: _____

Allergies: _____

Hearing Loss: Y N If yes, specify _____ Hearing Aid? Y N

Other Conditions and Medications:_____

_____

_____

_____

LIVING SITUATION: With whom does the patient live?_____

EMPLOYMENT STATUS:

____ Retired
____ On Leave
____ Homemaker
____ Employed Full-time
____ Employed Part-time
____ Unemployed/ Not seeking Employment
____ Unemployed / Seeking Employment

Reason for status or job description:_____

_____

Is your job in jeopardy? Y N n/a Have you considered retiring/resigning because of vision? Y N n/a

Social Activities (church, senior center, etc):_____
Other limitations (difficulty walking, tremors, etc):_____
Who will accompany patient to the exam?_____Relationship:_____
Phone: (____)_____-_____ Alt. Number:(____)_____-_____

TASK ANALYSIS: Circle eas as: n/a=not applicable N= not a problem Y= major problem
M= Mild problem O=Patient Objective

A. Traveling: Do you travel alone? Yes No (skip to B if answered No)

Do you have difficulty.....

1. Traveling locally alone?	n/a	N	M	Y	O
2. Traveling far?	n/a	N	M	Y	O
3. Seeing to drive a car?	n/a	N	M	Y	O
4. Seeing traffic lights?	n/a	N	M	Y	O
5. Seeing street signs?	n/a	N	M	Y	O
6. Crossing streets?	n/a	N	M	Y	O

B. Distance Viewing

Do you have difficulty.....

7. Getting around people / objects?	n/a	N	M	Y	O
8. Seeing curbs and stairs?	n/a	N	M	Y	O
9. Walking without falling?	n/a	N	M	Y	O
10. Seeing faces?	n/a	N	M	Y	O
11. Seeing at the theater?-	n/a	N	M	Y	O
12. Seeing the TV? (distance _____)	n/a	N.	M	Y	O

C. Daily living activities

Do you have difficulty.....

13. Doing your housework?	n/a	N	M	Y	O
14. Seeing to cook?	n/a	N	M	Y	O
15. Seeing stove dials?	n/a	N	M	Y	O
16. Seeing flame on stove?	n/a	N	M	Y	O
17. Seeing food on your plate?	n/a	N	M	Y	O
18. Seeing a phone/using a phone?	n/a	N	M	Y	O
19. Seeing to groom yourself?	n/a	N	M	Y	O

What is the patient's chief complaint?

_____
_____
_____
_____

What does the patient miss the most?

_____
_____
_____
_____

D. Near tasks:

Do you have difficulty.....

20. Reading headlines?	n/a	N	M	Y	O
21. Reading regular - print books?	n/a	N	M	Y	O
22. Reading phonebooks/small print?	n/a	N	M	Y	O
23. Seeing prices/labels?	n/a	N	M	Y	O
24. Reading your mail/bills?	n/a	N	M	Y	O
25. Reading handwritten material?	n/a	N	M	Y	O
26. Writing/signing name (checks, etc)?	n/a	N	M	Y	O
27. Seeing color?	n/a	N	M	Y	O
28. Filling a syringe (diabetics)?	n/a	N	M	Y	O
29. Seeing your medicine labels?	n/a	N	M	Y	O
30. Seeing to sew/knit/crochet?	n/a	N	M	Y	O
31. Seeing playing cards?	n/a	N	M	Y	O

OTHER:_____

E. Lighting considerations

Do you have difficulty.....

32. Tolerating the sun well?	n/a	N	M	Y	O
33. On cloudy/rainy days?	n/a	N	M	Y	O
34. Seeing in dim light?	n/a	N	M	Y	O
35. Going from bright to dim light?	n/a	N	M	Y	O
36. Do you wear sunglasses?	n/a	N	M	Y	O
37. Are the sunglasses effective?	n/a	N	M	Y	O
38. Does bright light help you?	n/a	N	M	Y	O

Preferred light source (please circle) Incandescent Fluorescent Hi-Intensity Other_____

F. Job / School related tasks (if Not applicable, please skip)

Do you have difficulty.....

39. Using a computer?	n/a	N	M	Y	O
40. Using tools/equipment?	n/a	N	M	Y	O
41. Reading instruments/indicator?	n/a	N	M	Y	O
42. Moving within worksite/school?	n/a	N	M	Y	O
43. Seeing the blackboard in class?	n/a	N	M	Y	O

Task analysis was completed by:_____

Addition History: (referenced by number/letter) (FOR DOCTOR'S USE ONLY)

_____

_____

_____

_____

_____

Major objectives:_____

_____

General description of patient:_____

Patient Attitude (e.g. realistic, depressed, anxious):_____

Eye report / Intake reviewed by: _____