Patient: ____

Scheduled Exam Date: __________________________

Independence / Visual Needs Questionnaire

How would you describe how things look to you (foggy, distorted, etc)?

Right eye: ____

Left eye: ____

Do you have hand tremors? ___________________

List any magnifiers or special type of glasses or enlarging devices you use:

____

Do you use any devices that speak out loud to you? ___________________

Do you use computers? ___________________

What are your main computer activities?

____

Do you use an e-reader like a Kindle, Nook or iPad? ___________________

Are you able to see the information on your cell phone? ___________________

Are you able to see the numbers on your home phone? ___________________

Check below what you can read with normal glasses:

☐ headline size print ☐ large print size print ☐ normal size print

Reading newspaper, books or magazines:

- ☐ **I read daily with nothing or normal glasses**
- ☐ **I manage to read some but have to use a magnifier or other device**
- ☐ **I have not read in (how long?)**_______________________________
- ☐ **I was never much for reading**
- ☐ **I miss reading a great deal**
- ☐ **I wish I could see to read better**

Do you need additional light to see well? ___________________

Do you need reduced light or glare in order to see well? ___________________

Would you describe yourself as sensitive to bright light? ___________________

Do you tend to use sunglasses? ___________________

Are they dark enough? ___________________ Too dark? ___________________

Is your night vision worse than typical? ___________________

How is your mobility? _______________________________________

Do you have trouble with curbs or steps? ___________________

Do you use a cane? ___________________**White cane?** ___________________

Have you ever had white cane training? ___________________

Do you walk places outside your home by yourself? ___________________

Can you see street crossing signs? ___________________

Do you drive? ___________________

When did you last drive? _______________________________________

When does your license expire? _______________________________________

Do you drive places alone? ___________________

Do you drive at night? ___________________

While driving, have you had a close call or been in an accident that was considered your fault in the past 3 years? ___________________

Do you use public transportation? ___________________

Do you watch / listen to television? ___________________

How big is the TV that you most often watch? _______________________________

How far away do you usually sit? _______________________________________

With whom do you live or alone?______________________________________

Do you have a caregiver/how often? ______________________________________

What type of home do you live in, two story, single story, apartment, retirement center, assisted living, etc? ______________________________________

Current or recent hobbies / Leisure activities: ________________________________

Please check below: **I need to see better to feel more confident in these areas:**

- ☐ **Kitchen**
- ☐ **Grooming/hygiene**
- ☐ **Laundry**
- ☐ **Writing /mail / bills**
- ☐ **Shopping**
- ☐ **Driving**
- ☐ **Reading**

Other: ______________________________________