Dear Valued Patient,

Thank you for inquiring about our low vision services. Your in-office evaluation will include a comprehensive history, a discussion of your specific needs and goals, a review of the cause of your visual impairment, and a complete low vision examination. At the conclusion of the visit, we will review our findings with you and those who have accompanied you. The fee for this visit will be $215. Some insurance policies, including Medicare, will defray most of the cost. Please feel free to inquire about this.

Once it has been determined that a low vision device(s) will be useful, a referral to a home program to help you learn to use the device(s) may be instituted. You will be monitored for success both at home and in our office.

Patients generally come to us by referral. Please continue to return to your doctor to continue your eye health monitoring and care. **Please come about 15 minutes prior to your appointment time** so the staff can start with your case history. Bring your glasses and any low vision devices or magnifiers that you may use.

If we can be of assistance, please contact us at **949-646-4949.**

Sincerely,

Michael Bourgoin, O.D.

Patient Name:_____ Date:_____

We have enclosed this questionnaire to help us improve our knowledge about your vision problems and how they affect your quality of life. Please take as much time as

you need to answer each question. Feel free to ask any family or friends if you need help reading the questions, or call us if you have any questions. All your answers are confidential. If you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

What are your Major Objectives for your low vision consultation? Or what things you would most like to be able to do more easily concerning your vision?

1.

_____

2.

_____

3.

_____

4.

_____

Please circle your appropriate answers.

Has your vision changed in the past month? **Yes No**
Has your vision changed since your last exam? **Yes No**

Do you have hearing loss? **Yes No** Hearing Aid? **Yes No**

Living situation: Alone Spouse With children Retirement Home
Nursing Home Aide

Employment status: Retired On leave Homemaker
Employed full time Employed part time
Unemployed / seeking employment Unemployed / not seeking employment
Is your job in jeopardy because of your vision? **Yes No**
Have you considered retiring/resigning because of your vision? **Yes No Other**

Limitations: Difficulty walking Tremors Hand / Arm weakness

Current Low Vision Aids (List all with correct powers):

Home:_____

School: _____

Job: _____

- *TASK ANALYSIS*

Please answer the following questions by circling one of the following appropriate answers for each question.

Not Applicable **(NA**)
No Problem (**N**)
Mild Problem (**M**)
Yes, Major Problem (**Y**)
Patient's Objective (**O)** (This would be one of your main objectives for your low vision consultation)

TRAVELING:
Do you go out alone? **Yes No**
Do you want to go out alone? **Yes No** (If no, skip to question **8**)
Do you use a cane/dog as an aid to navigation? **Yes No**
Have you had Orientation & Mobility instruction? **Yes No Not Sure**

Do you have Difficulty?

1. Traveling locally alone? **N/A N M Y O**
2. Traveling far alone? **N/A N M Y O**
3. Seeing traffic lights? **N/A N M Y O**
4. Seeing street signs? **N/A N M Y O**
5. Crossing streets? **N/A N M Y O**
6. Seeing to drive a car? **N/A N M Y O**
7. Do you want Orientation & Mobility instruction **N/A Yes___ No____**

DISTANCE VIEWING: Do you have difficulty:

8. Getting around people/objects? **N/A N M Y O**
9. Seeing curbs and steps? **N/A N M Y O**
10. Walking without tripping? **N/A N M Y O**
11. Seeing faces? **N/A N M Y O**
12. Seeing at the theater? **N/A N M Y O**
13. Seeing TV? **N/A N M Y O**
How far do you sit from the TV? _____

DAILY LIVING ACTIVITIES: Do you have difficulty?

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

NEAR TASKS: Do you have difficulty?

21. Reading headlines? **N/A N M Y O**
22. Reading regular print books? **N/A N M Y O**
23. Reading newsprint /small print? **N/A N M Y O**
24. Seeing prices or labels? **N/A N M Y O**
25. Reading your mail or bills? **N/A N M Y O**
26. Reading hand written material? **N/A N M Y O**
27. Writing/signing your name? **N/A N M Y O**
28. Seeing colors? **N/A N M Y O**

29. Seeing to sew / knit /crochet? **N/A N M Y O**
30. Seeing playing cards? **N/A N M Y O**
31. Seeing your meds / labels? **N/A N M Y O**
32. Seeing to fill a syringe (diabetics)? **N/A N M Y O**
33. Social Activities:_____

_____

_
_____

_

LIGHTING CONSIDERATIONS: Do you have problems?

34. Tolerating the sun? **N/A N M Y O**
35. Glare Problems Indoors **N/A N M Y O**
36. Glare from Computer **N/A N M Y O**
37. On cloudy / rainy days? **N/A N M Y O**
38. Going from bright to dim light? **N/A N M Y O**
39. Seeing in dim light? **N/A N M Y O**
40. Do you wear sunglasses? **N/A N M Y O**
41. Are the sunglasses effective? **N/A N M Y O**
42. Does a bright light help you? **N/A N M Y O**

JOB RELATED TASKS: **Do you have problems?**

43. Using a computer? **N/A N M Y O**

Has computer been modified for Large Print or speech? **Yes_____No____**

44. Using tools / equipment? **N/A N M Y O**

45. Traveling in work site? **N/A N M Y O**

46. Seeing distant presentations? **N/A N M Y O**

Please bring this completed questionnaire with you to your appointment.