MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

What is the **cause of your vision loss**? (Diagnosis)
R_____ L_____

When did you first have difficulty with your vision?
R_____ L_____

Which is your better seeing eye? R L

Did you ever have any **treatment or surgery, including laser, on your eyes**?

Date	Procedure	R/L	Doctor

Have you ever had an **eye injury**?

Are you using any **eyedrops**?

R/L	Medication	Dosage	How often?

Is there any **family history** of glaucoma, cataract, blindness or other vision problem?

Are you currently taking any **medications**, prescription or over the counter, including aspirin?

Medication	Dosage	How often?	For what reason

Do you have any **allergies** to any medications? [ ] YES [ ] NO
If YES, list the medications:

Is there any **family history** of diabetes, high blood pressure, heart attack, stroke or other medical condition?

Have you ever had a Low Vision Evaluation? By whom and what was the outcome?

What do you hope to accomplish by this Low Vision Evaluation?

Are there any activities you miss doing because of your decreased vision?
Please list:

Do you use any glasses or low vision aids to help you see? If you do, please bring them with you to the Evaluation.

Can you get around alone **indoors** even in unfamiliar surroundings?

Can you get around alone **outdoors** even in unfamiliar surroundings?

Does **sunlight** bother your eyes?

Are you able to get around in **dimly** lit surroundings?

Can you see **road signs** or **street signs**?

Can you see **traffic lights**?

Do you watch **TV**?

Can you read newspaper **headlines**?

Can you read **newsprint**?

Can you read/take care of your own **mail** or bills?

Can you see well enough to use the **telephone**?