The Lighthouse for the Blind, Inc.

Low Vision Clinic: Medical History Intake Form

Name: _____ Date of Birth: _____

What are your main concerns about your vision?

Functional Difficulties due to Vision Loss: *(please check all that apply)*

[__] reading, writing

[__] watching television

[__] household activities

[__] using technology (cell phones, computers, etc.)

[__] moving around safely (falls)

[__] feeling nervous or down

[__] getting or keeping a job

[__] Other:

Social/Environmental History

Occupation: _____ Marital Status: _____

Are you a Veteran of the Armed Forces: Yes _____ No _____

Living Arrangements: Alone____ With Spouse_____

With Family _____ Other: _____ Retirement Community_____

Do you currently drive? Yes ___ No __ If yes: Day _____ Night _____

Do you currently wear glasses? Yes __ No __

If yes: How old is your prescription? _____

Do you use magnifiers, telescopes or electronics to help you see better? Yes__ No__

If yes, what type: _____

Have you ever had any surgery on your eyes? Yes___ No___

Do you use tobacco? Yes___ Never___ Used to but not now____

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Ocular Problem List *(please check all that apply)*

[_] Blurred vision **[_] Distorted vision** **[_] Loss of side vision**

[_] Loss of central vision **[_] Double vision** **[_] Glare/light sensitivity**

[_] Glaucoma **[_] Stroke** **[_] Macular Degeneration**

[_] Retinal Detachment **[_] Cataracts** **[_] Amblyopia (lazy eye)**

[_] Inherited Retinal Disorders (Leber Congenital Amaurosis (LCA), Retinitis Pigmentosa, Choroideremia, Stargardt's Disease, and Achromatopsia)

[_] Other:

Medical History

List all allergies and reactions:

_____

List all major illnesses, current or past:

_____

List major surgeries:

_____

Family medical and eye history

Mother:

_____

Father:

_____

Siblings:

_____