Welcome to the Low Vision Institute

Registration Form: If this is your first visit to our office please complete this form and give it to the receptionist along with you driver's license and insurance card. If you are a previous patient then please update any information which has changed since you last visit to our office.
Please **PRINT** all information.

Name_____ **Date**_____
Address_____
City_____ **State** _____ **Zip Code**_____
Home Phone_____ **Work/Cell Phone**_____
SS#_____ **DOB:**_____ **Age:**____ **Sex: M**___ **F**___
Occupation_____ **Marital Status**_____ **Spouse's Name**_____
Emergency Contact_____
Phone_____ **Relationship**_____

Present Eye Doctor _____ **Phone** _____
Retinal Doctor_____ **Phone** _____
Family Doctor_____ **Phone**_____
How did you hear about our office? _____

Primary Insurance _____ **Co-Pay $**_____
ID #_____
Secondary Insurance_____
ID# _____

Have you had a low vision examination before? Yes____ **No**_____
If yes, where, when, etc.? _____
Do you have any low vision aids at this time? Yes____ **No**_____
If yes, what visual aids do you have? _____

Insurance Authorization: I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning my illness, accident and/or treatments and I hereby irrevocably assign to the above physicians all payments for financially responsible for all charges whether or not covered by insurance. I also hereby authorize you to obtain copies of my medical records from other physicians if necessary. A photocopy of this authorization shall be considered as effective and valid as the original. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Patients Signature: _____
OFFICE SEEN AT _____

Patient Name: _____ Date: _____

Eye History

__ Cataract: Extraction in either eye? □Yes □No

When, which eye, etc? _____

__Macular Degeneration: □Laser Treatments □Injections □None

When, which eye, etc? _____

__Eye Injury: __ Eye Disease: __Eye Surgery: _____

__ Glaucoma: _____

__ Blindness: _____

__ Retinal Detachments: _____

__ Strabismus: _____

__ Other (please specify): _____

General Health History:

__ High Blood Pressure: _____

__ Diabetes: _____

__ High Cholesterol: _____

__Cancer: _____

__Anemia: _____

__Thyroid Disease: _____

__ Arthritis: _____

__Lupus: _____

__Tuberculosis: _____

__Nervous Condition: _____

__Other (please specify): _____

Social History: Do you currently (if checked, list type, amount, and duration of use)

__Use Tobacco Products: _____

__ Drink Alcohol: _____

__Use Illegal drugs: _____

Have you ever been exposed to or infected with: __Gonorrhea __Hepatitis __HIV __Syphilis

Patient Name: _____ Date: _____

Review of Systems:

Constitutional: __Fever, Weight Loss/Gain: _____

Integumentary: __ Skin conditions/Disease: _____

Neurological: __ Headache □Sharp □Dull □Throbbing Severity (1-10): _____

Onset: _____

Position: _____

Duration: _____

□ Nausea □ Dizziness □ Other: _____

Eye: __Loss of Central Vision __Loss of Side Vision __ Double Vision __ Dryness
__Redness __Itching __Eye Pain __Burning __Mucous Discharge
__Excessive Watering/Tearing __Chronic infections of eyelids
__Sandy or Gritty Feeling __Styes or Chalazion __Flashing Lights __ Floating Spots
__Halos around Lights __Fluctuating Vision or Fatigue __Blurred/Distorted Vision
__ Night Vision Problems __Glare of Light Sensitivity

Endocrine: __Thyroid or other glandular disorders: _____

Ears, Nose, Mouth, Throat: __Allergies/Hay Fever __Runny Nose __Chronic Cough
__ Sinus Congestion __Post Nasal Drip __Dry Throat/Mouth

Respiratory: __Asthma __Emphysema __Chronic Bronchitis

Vascular/Cardiovascular: __Diabetes: _____
__High Blood Pressure __Heart Pain __High Cholesterol __Vascular Disease
__ Stroke: _____

Gastrointestinal: __Diarrhea __Constipation: _____

Genitourinary: __Genital/Kidney/Bladder Disorders: _____

Bones/Joints/Muscles: __Arthritis __Joint Pain __Muscle Pain

Lymphatic/Hematologic: __Anemia __Bleeding Problems

Allergies/Immunologic: _____Medicine Allergies _____
_____Other Allergies _____

Psychiatric: __Any Neurological or Mental Disorders/ Conditions: _____

Major Surgery: _____
_____
_____

Medications: _____
_____
_____

Patient Name: _____ Date: _____

THE LOW VISION INSTITUTE

VISUAL FUNCTION QUESTIONAIRE

ARE YOU ABLE TO DO THE FOLLOWING?

DISTANCE TASK

YES	NO	N/A		YES	NO	N/A	
□	□	□	OVERHEAD SIGNS IN GROCERY STORE	□	□	□	CROSSING THE STREET ALONE
□	□	□	SEEING TO DRIVE A CAR	□	□	□	SEEING CURBS/ STEPS
□	□	□	RECOGNIZING STREET SIGNS	□	□	□	SEEING THE TELEVISION
□	□	□	SEEING TRAFFIC LIGHTS	□	□	□	SEEING AT THE THEATER
□	□	□	RECOGNIZING PEOPLES FACES				

NEAR TASKS

YES	NO	N/A		YES	NO	N/A	
□	□	□	READING HEADLINES	□	□	□	IDENTIFYING MEDICATIONS
□	□	□	READING THE NEWSPAPER	□	□	□	READING THE MAIL
□	□	□	READING REGULAR PRINT BOOKS	□	□	□	WRITING/ SIGNING YOUR NAME
□	□	□	PAYING YOUR BILLS	□	□	□	SEEING TO SOW, KNIT, CROCHET
□	□	□	SEEING TO PLAY CARDS	□	□	□	SEEING THE COMPUTER

DAILY LIVING ACTIVITIES

YES	NO	N/A		YES	NO	N/A	
□	□	□	DOING YOUR HOUSEWORK	□	□	□	SEEING FOOD ON YOUR PLATE
□	□	□	SEEING TO GROOM YOUSELF	□	□	□	SEEING STOVE DIALS
□	□	□	SEEING/ USING TELEPHONE				

LIGHTING CONSIDERATIONS

YES	NO	N/A		YES	NO	N/A	
□	□	□	TOLERATE SUNLIGHT	□	□	□	DO YOU WEAR SUNGLASSES
□	□	□	TOLERATE GLARE	□	□	□	DO SUNGLASSES HELP YOU

SET TEST ___ANIMALS+ ___COLORS+ ___FRUITS/VEGTABLES+ ___CITIES/TOWNS= _____

WISH LIST

1. _____ 3. _____
2. _____ 4. _____