SB Optical

Low Vision Solutions Inc.

1242 St. Clair Ave. West
Toronto, ON
M6E1B7

Tel: 647-748-4577

PATIENT NAME: _____

DATE OF APPOINTMENT: _____

TIME OF APPOINTMENT: _____

You are about to go through a vision assessment in which we will determine how to effectively enhance your vision abilities by the use of different kinds of visual aids. We will recommend devices that will enable you to function and perform your daily tasks easily.

We welcome you to our services!

How can you prepare for your appointment?
Please make sure you complete the attached patient questionnaire before arriving to your appointment.

The questionnaire will help us identify problems you experience due to loss of vision.
Don't forget to bring the questionnaire with you.

What else should you bring?
Any glasses, sunglasses, or magnifiers you are currently using.

Who can attend your appointment?
We encourage you to bring a spouse, relative or friend that can accompany you.

How does low vision rehabilitation works?

To receive the best prescription for your eyes we will meet multiple times. This will assure that all the goals and tasks you would like to accomplish are being met.

Throughout your visits, you will learn how to use new devices that will maximize your current vision. You will also learn how to take care of your new devices.

We are here to help you in every step of the way! After some practice, you will be able to use your new optical aids successfully.

Below are a few questions that will help us identify the problems in your vision.
Please write down your answers
OR circle YES or NO when applicable.

I. Visual History

How long have you had vision problems?

_____

Have you ever had a low vision evaluation?
YES/ NO

II. General Vision

Do you use magnifiers?	YES/ NO
Does sunlight bother your eyes?	YES/ NO
Do you wear sunglasses?	YES/ NO
Are you bothered by glare?	YES/ NO
Do you have trouble with your vision at night (indoor or outdoor)?	YES/ NO
Do you have problems seeing in dim light?	YES/ NO

III. Do you have any vision problems with the following?

Eating	YES/ NO
Sewing	YES/ NO
Watching Television	YES/ NO
Watching Movies/Theater	YES/ NO
Playing Cards	YES/ NO
Using a Computer	YES/ NO
Reading Labels (ex: food labels/ medication labels)	YES/ NO
Cooking	YES/ NO
Reading Price Tags	YES/ NO
Reading Receipts	YES/ NO
Using the Telephone	YES/ NO
Seeing Food on Plate	YES/ NO
Crossing Streets	YES/ NO
Seeing/Reading Bus Numbers	YES/ NO
Seeing/Reading Street Signs	YES/ NO
Recognizing People	YES/ NO

IV. Do you have reading problems in the following?

Printed Materials	YES/ NO
Newspaper Headlines	YES/ NO
Newspaper	YES/ NO
Magazines	YES/ NO
Telephone Book	YES/ NO
Large Print Books	YES/ NO
Small Print Books	YES/ NO
Mail	YES/ NO
Music Notes	YES/ NO

Does reading make you tired quickly? YES/ NO

What kind of light do you use for reading? (Circle)
Fluorescent / incandescent / halogen

Did you read more prior to your vision loss?
YES/ NO

Do you want to read more than you presently can?
YES/ NO

Do you have problems in writing?
Yes/ NO

V. Tell me more about some of the major activities in your daily routine.

_____

_____

_____

VI. What tasks would you like us to concentrate on helping you with first?

_____

_____

_____

VII. Work and Education

Are you retired?	YES/ NO
Are you working?	YES/ NO
If yes, please describe your job	
Are you a student?	YES/ NO

Thank you very much for your cooperation!
We look forward to meeting you.