L|O|EYE CARE

About My Vision

Please complete these 2 pages and bring them to your appointment.

The following are difficult because of my vision loss:

_ Cleaning
_ Cooking
_ Eating
_ Grooming
_ Identifying money
_ Managing finances
_ Reading
_ Recognizing faces
_ Sewing
_ Shopping
_ Telling Time
_ Transportation
_ Using the phone
_ Watching TV
_ Writing
_ Other: _____

_____

I currently use the following low vision aids or services:

_ Magnifiers
_ Special glasses
_ Video Magnifier (CCTV)
_ Talking books
_ Large Print Materials
_ Other: _____

_____

My best eye is: ___ Right ___Left

The most frustrating thing about my vision loss is: _____

_____

_____

_____

_____

_____

I would like to do the following but cannot because of my vision loss: _____

_____

_____

_____

_____

_____