Low Vision Questionnaire
Strasburg Family Eyecare, LLC
717-687-8141

Name: _____ DOB: _____ Phone: _____

1. **To prepare for your appointment, please answer the following questions:**
2. **Please think about different vision tasks that you find difficult and list them below. You might wish to treat this like a diary and when ever you have a problem with vision, write it down. Also take note of the lighting in that location. The day before your appointment, please prioritize the tasks below in order of their importance.**
3. **Does Sunlight bother your eyes? Yes / No**
4. **Do you wear eyeglasses? Yes / No**
5. **If yes, please bring them with you**
6. **Are you using any magnifying vision aids? Yes / No**

Vision Task	Location/Room	Lighting
Reading newspaper	Kitchen	Overhead 6o w bulb

Please bring with you to your appointment