

Appendix 2: Evaluation Form for the Acquired Monocular Vision Patient

PROBLEM FOCUSED HISTORY

NAME: _____ DOB & AGE: _____, _____ years ORIG. DATE: _____
ADDRESS: _____ PHONE: _____
REFERRED BY: _____ ACCOMPANIED BY: _____

PLACE OF SERVICE: OFFICE 11 New DATE LAST SEEN: _____

1) HISTORY OF VISION:

A) DATE OF LAST OPHTHALMOLOGIC EXAM: _____ BY: DR. _____
B) SUBSEQUENT DIAGNOSIS & TREATMENT: (TRAUMA) (TUMOR) (GLAUCOMA) (INFECTION) (OTHER): _____
_____ ; date of vision loss _____

Eye removed? OD OS no; Ocular prosthesis? OD OS no; Patient reports history of _____

BETTER EYE: OD OS Better eye is DOMINANT EYE?: yes no
NO LIGHT PERCEPTION: OD OS Psychological reaction to loss of an eye: _____

2) GENERAL HEALTH: patient history of _____

MEDICATION: patient reports taking _____

3) OBSERVATIONS:

ENTRY ROOM/CHAIR: natural hesitant needs assistance other: _____
PERSONALITY: neutral outgoing withdrawn
ALERTNESS: good fair poor

4) MOBILITY:

WALKS ABOUT: alone (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
STEPS, STAIRS AND CURBS: (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
BUMPING INTO PEOPLE?: (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
CUTTING PEOPLE OFF?: (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
ASSOCIATED NECK PAIN? (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
DRIVING: (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)

5) DISTANCE VISION:

WATCHES TV? (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)

6) ILLUMINATION: patient reports glare (slightly) (moderately) (severely) (does not) bother(s); patient reports utilizing _____
to reduce glare; patient reports glare reducing filters are (sufficient) (not sufficient).

7) NEAR VISION: patient reports utilizing _____ ;

FATIGUE WHILE READING? (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
LOOSING ONES PLACE? (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)
SPILLS OCCUR WHEN POURING? (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)

8) EMPLOYMENT: (yes) (no) Type of work: _____ difficulty?: (none) (mild) (moderate) (severe)
patient reports hobbies: _____ difficulty?: (none) (mild) (moderate) (severe)

9) MAIN CONCERNS / REASONS FOR VISIT / MEDICAL NECESSITY:

COSMETIC APPEARANCE?: (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)

ABILITY TO PERFORM SPORTS?: (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)

ABILITY TO WORK? (yes) (no) if yes, difficulty?: (none) (mild) (moderate) (severe)

Patient is partially sighted due to _____. Patient would like to _____.

Patient would also like to know any treatment or management options available to help function better with acquired monocular vision.

HISTORY COMPLETED BY: _____