



**SKIPPACK EYECARE
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Low Vision Assessment

Do you have difficulties in the following?

Traveling locally alone?	N/A	YES	NO
Traveling far alone?	N/A	YES	NO
Crossing streets?	N/A	YES	NO
Do you drive?	N/A	YES	NO
Seeing traffic lights?	N/A	YES	NO
Seeing street signs?	N/A	YES	NO
Seeing fellow cars?	N/A	YES	NO

Reading headlines?	N/A	YES	NO
Reading regular print books?	N/A	YES	NO
Reading small prints?	N/A	YES	NO
Reading prices/labels?	N/A	YES	NO
Reading mails?	N/A	YES	NO
Reading handwritten materials?	N/A	YES	NO
Seeing to write?	N/A	YES	NO
Seeing colors?	N/A	YES	NO
Seeing to sew, knit	N/A	YES	NO
Seeing medications?	N/A	YES	NO

Moving around people/objects?	N/A	YES	NO
Seeing curbs & steps?	N/A	YES	NO
Walking without tripping?	N/A	YES	NO
Fall in the last 6 months?	N/A	YES	NO
Seeing faces?	N/A	YES	NO
Seeing tv?	N/A	YES	NO
Seeing at the movies?	N/A	YES	NO

Tolerating the sun?	N/A	YES	NO
Glare issue inside?	N/A	YES	NO
Glare from computer?	N/A	YES	NO
On cloudy/rainy days?	N/A	YES	NO
Going from bright to dim lights?	N/A	YES	NO
Seeing in dim lights?	N/A	YES	NO
Do you wear sunglasses?	N/A	YES	NO
Are sunglasses effective?	N/A	YES	NO
Does bright light help?	N/A	YES	NO
Bright light issues	N/A	YES	NO

Working your assignment?	N/A	YES	NO
Seeing to cook?	N/A	YES	NO
Seeing the stove dials?	N/A	YES	NO
Seeing the stove's flame?	N/A	YES	NO
Seeing food on your plate?	N/A	YES	NO
Seeing/using your phone?	N/A	YES	NO
Seeing to groom yourself?	N/A	YES	NO