ARIZONA EYE CONSULTANTS

Low Vision Intake Form

Current Date:_____

Name:_____ Date of Birth:_____

Gender:_____

Phone Number:_____

Email Address:_____

Mailing Address: _____

Emergency Contact (Name, Relationship, Phone Number):

Name:_____

Relationship:_____

Phone Number:_____

Vision Information

Eye Condition (ex. Glaucoma, dry macular degeneration, diabetic retinopathy, etc):

_____

_____

Ocular Surgeries (ex. Cataract surgery, trabeculectomy, injections, laser, etc):

_____

_____

ARIZONA EYE
CONSULTANTS

What visual tasks would you like help with? Please list specific goals (ex. Watching TV, bird watching, reading mail, reading restaurant menus, etc.) and bring examples of said material if applicable. In the case that not all goals are able to be addressed at the first visit due to the time constraint, follow ups can be scheduled.

If you are currently using any devices, please list them.

If there is a particular device you heard about and would be interested in, please list them.

Is there any other information you would like us to know about?

Provider  ARIZONA EYE CONSULTANTS Information

We will forward a report to the following providers after your appointment.

Ophthalmologist (MD)

Name:_____

Phone Number: _____

Date of Last Exam: _____

Optometrist (OD)

Name:_____

Phone Number: _____

Date of Last Exam: _____

Primary Care Provider

Name:_____

Phone Number: _____

Date of Last Exam: _____