



Please indicate:
_____ initial visit
_____ follow-up

Date: _____ Student Name: _____

TVI: _____ (To be Completed on Students 19 – 21 years of age)

Impact of Vision Impairment Profile (IVI)

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INSTRUCTIONS: Please read each question carefully and circle the answer that **BEST** applies to you. Put one circle on each row.

If you use **GLASSES, CONTACT LENSES OR MAGNIFIERS** for some activities please answer according to how you can see when using them.

Here are two examples:

In the past month how often has your eyesight made you concerned or worried about...

	Not at all	A little	A fair amount	A lot	Don't do This for Other reasons
Crossing the street?	3	2	1	0	8
Preparing a meal for yourself?	3	2	1	0	8

PLEASE START HERE AND REMEMBER:

Put one circle on each row. Please do not leave any rows blank.

Please answer about YOUR eyesight with GLASSES, CONTACT LENSES, or MAGNIFIERS, if you use them. In the PAST MONTH, how much has YOUR EYESIGHT INTERFERED with the following activities:

	Not at all	A little	A fair amount	A lot	Don't do this for other reasons
1. Your ability to see and enjoy T.V?	3	2	1	0	8
2. Taking part in recreational activities such as bowling, walking or golf?	3	2	1	0	8
3. Shopping? (finding what you want and paying for it)	3	2	1	0	8
4. Visiting friends or family?	3	2	1	0	8
5. Recognizing or meeting people?	3	2	1	0	8
6. Generally looking after your appearance? (face, hair, clothing etc.)	3	2	1	0	8
7. Opening packaging? (for example, around food, medicines)	3	2	1	0	8

Please answer about YOUR eyesight with GLASSES, CONTACT LENSES, or MAGNIFIERS, if you use them. In the PAST MONTH, how much has YOUR EYESIGHT INTERFERED with the following activities:

	Not at all	A little	A fair amount	A lot	Don't do this for other reasons
8. Reading labels or instructions on medicines?	3	2	1	0	8
9. Operating household appliances and the telephone?	3	2	1	0	8
10. How much has your eyesight interfered with getting about outdoors? (on the pavement or crossing the street)	3	2	1	0	8
11. In the past month, how often has your eyesight made you go carefully to avoid falling or tripping?	3	2	1	0	8
12. In general, how much has your eyesight interfered with travelling or using transport? (bus & train)	3	2	1	0	8
13. Going down steps, stairs, or curbs?	3	2	1	0	8

Please answer about **YOUR** eyesight with **GLASSES, CONTACT LENSES, or MAGNIFIERS**, if you use them. In the **PAST MONTH**, how much has **YOUR EYESIGHT INTERFERED** with the following activities:

	Not at all	A fair amount	A lot	Don't do this for other reasons
14. Reading ordinary size print? (for example newspapers)	2	1	0	8
15. Getting information that you need?	2	1	0	8

Please answer about **YOUR** eyesight with **GLASSES, CONTACT LENSES or MAGNIFIERS**, if you use them. In the **PAST MONTH**, how often has **YOUR EYESIGHT MADE YOU CONCERNED OR WORRIED** about the following:

	Not at all	A little of the time	A fair amount of the time	A lot of the time
16. Your general safety at home?	3	2	1	0
17. Spilling or breaking things?	3	2	1	0
18. Your general safety when out of your home?	3	2	1	0
19. In the past month, how often has your eyesight stopped you doing the things you want to do?	3	2	1	0
20. In the past month, how often have you needed help from other people because of your eyesight?	3	2	1	0

Please answer about YOUR eyesight with GLASSES, CONTACT LENSES or MAGNIFIERS, if you use them. Think about how YOUR eyesight has made you FEEL in the PAST MONTH.

	Not at all	A little of the time	A fair amount of the time	A lot of the time
21. Have you felt embarrassed because of your eyesight?	3	2	1	0
22. Have you felt frustrated or annoyed because of your eyesight?	3	2	1	0
23. Have you felt lonely or isolated because of your eyesight?	3	2	1	0
24. Have you felt sad or low because of your eyesight?	3	2	1	0
25. In the past month, how often have you worried about your eyesight getting worse?	3	2	1	0
26. In the past month how often has your eyesight made you concerned or worried about coping with everyday life?	3	2	1	0
27. Have you felt like a nuisance or a burden because of your eyesight?	3	2	1	0
28. In the past month, how much has your eyesight interfered with your life in general?	3	2	1	0

Please check that you have answered all the questions. Thank you!