Supplemental Material 1

Low Vision Screening Questionnaire

Name of Field Worker**:** _____ Date & Day**:**_____

Village Name**:**_____ Time**:**_____

Low Vision Patient Details

Name**:**_____ Age**:**_____ Sex**:**_____

Address**:**_____

Contact Number**:**_____

1. Birth History
   - Preterm ○ Full term
2. Birth Weight:_____
3. Milestones:
   - Normal ○ Delayed
4. Any other medical conditions:_____
5. Vision right eye:_____ Vision left eye:_____
6. Age low vision was identified:_____
7. Cause of low vision:
   - Present at birth ○ Disease/syndrome
   - Accident ○Other:_____
8. Blindness Status
   - Partially blind ○ Fully blind
9. Has patient seen an ophthalmologist?
   - No
   - Yes- if yes vision right eye:_____ vision left eye:_____
10. Attends school
    - No
    - Yes- if yes: ○ normal school ○ integrated school ○ blind school
11. Socioeconomic status (annual income of parents)
    - Less than Rs. 72,000
    - Rs. 72,000 or more
12. Family Details: _____
13. Family History of Blindness?
    - No ○ Yes- if yes:_____
14. Photophobia?
    - Yes ○ No
15. Night Blindness?
    - Yes ○ No
16. Does the patient use low vision devices?
    - No ○ Yes- if yes:_____