**APPENDIX A**

## Turano Questionnaire

Directions: After thinking of each mobility situation given below, report the number which best expresses the level of difficulty you feel in the situation without any assistance (cane, companion, guide dog, etc.) on a scale of 1 to 5; 1 represents no difficulty, and 5 represents extreme difficulty.

1. Walking in familiar areas
2. Walking in unfamiliar areas
3. Moving about at home
4. Moving about at work
5. Moving about in the classroom
6. Moving about in stores
7. Moving about in outdoors
8. Moving about in crowded situations
9. Walking at night
10. Using public transportation
11. Detecting ascending stairwells
12. Detecting descending stairwells
13. Walking up steps
14. Walking down steps
15. Stepping onto curbs
16. Stepping off curbs
17. Walking through doorways
18. Walking in high-glare areas
19. Adjusting to lighting changes during the day – indoor to outdoor
20. Adjusting to lighting changes during the day – outdoor to indoor
21. Adjusting to lighting changes during the night – indoor to streetlights
22. Adjusting to lighting changes during the night – streetlights to indoor
23. Walking in dimly lit indoor areas
24. Being aware of another person’s presence
25. Avoiding bumping into: People

26. Avoiding bumping into: Walls
27. Avoiding bumping into: Head-height objects
28. Avoiding bumping into: Shoulder-height objects
29. Avoiding bumping into: Waist-height objects
30. Avoiding bumping into: Knee-height objects
31. Avoiding bumping into: Low-lying objects
32. Avoiding tripping over uneven travel surfaces
33. Moving around in social gatherings
34. Finding restrooms in public places
35. Seeing cars at intersections

Do you limit travel by yourself due to your vision loss? [Yes/No]

How often do you ask someone to accompany you when you leave your house? [Always/Usually/Sometimes/Never]

Are you satisfied with your present level of travel? [Yes/No]

Do you use a mobility aid (e.g., guide dog, cane, sighted companion)? [Yes/No]

Do you believe that your ability to travel on foot by yourself is less than that of people with normal vision? [Yes/No]

# APPENDIX B

**National Eye Institute**

**Visual Functioning Questionnaire – 25 (VFQ-25) version 2000**

1. How much difficulty do you have reading street signs or the names of stores?
2. Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?
3. Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?
4. Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?
5. Do you accomplish less than you would like because of your vision?
6. Are you limited in how long you can work or do other activities because of your vision?
7. I stay home most of the time because of my eyesight.
8. I feel frustrated a lot of the time because of my eyesight.
9. I have much less control over what I do, because of my eyesight.
10. Because of my eyesight, I have to rely too much on what other people tell me.
11. I need a lot of help from others because of my eyesight.
12. I worry about doing things that will embarrass myself or others, because of my eyesight.