

	YES	NO
GENERAL / CONSTITUTIONAL (fever, weight loss...)	_____	_____
EARS, NOSE, THROAT (stuffy nose, ear ache ...)	_____	_____
CARDIOVASCULAR (high blood pressure...)	_____	_____
RESPIRATORY (congestion, wheezing, asthma...)	_____	_____
GASTROINTESTINAL (stomach upset, diarrhea...)	_____	_____
GENITAL, KIDNEY, BLADDER	_____	_____
MUSCLES, BONES, JOINTS (joint pain...)	_____	_____
SKIN (growths, rash...)	_____	_____
NEUROLOGICAL (numbness, headache, seizures...)	_____	_____
PSYCHIATRIC (anxiety, depression, insomnia...)	_____	_____
ENDOCRINE (diabetes, thyroid...)	_____	_____
BLOOD / LYMPH (high cholesterol, anemia...)	_____	_____
ALLERGIC / IMMUNOLOGIC (sneezing, itching...)	_____	_____

FAMILY HISTORY			Relation to you
Blindness	_____	_____	
Glaucoma	_____	_____	
Retinal detachment	_____	_____	
Macular degeneration	_____	_____	
Cataracts	_____	_____	
Heart disease or high blood pressure	_____	_____	
Diabetes	_____	_____	
Stroke	_____	_____	
Cancer	_____	_____	

SOCIAL HISTORY		
Current occupation and employer _____		
Education (high school, vocational school, college, professional)		
Marital status (married, divorced, single, widowed)		
Do you drive?	_____	_____
Do you have visual difficulty when driving?	_____	_____
Do you currently wear contact lenses?	_____	_____
Do you currently wear eyeglasses?	_____	_____
Have you ever had a blood transfusion?	_____	_____
Do you drink alcohol?	_____	_____
Do you smoke?	_____	_____

***While federal law requires all lenses to meet a standard of impact resistance, lenses used for dress eyewear are not required to meet as rigorous an impact resistance standard as lenses used in industrial or sports spectacles. Of all the materials that lenses can be made from, polycarbonate is the most impact resistant (OLA 1998). Please let us know if you have concerns about lens safety so your specific needs can be addressed.

***Attention Contact Lens Wearers: The fitting and wearing of contact lenses require professional considerations that are beyond the scope of a routine eye examination. For all contact lens wearers, a contact lens related fee will apply.

***I authorize Dr. Miller and his staff to use the appropriate means of caring for my eyes, such as glaucoma testing, dilation drops, treatment programs, or any procedures deemed necessary.

***I authorize Dr. Miller and his staff to release any information necessary to process insurance claims and I certify that the information is correct.

***I authorize Dr. Miller and his staff to communicate with those persons involved in my healthcare.

***I also hereby agree to pay any and all charges that exceed or are not covered by insurance.

***These authorizations are in effect until I revoke them in writing.

Signature (patient or guardian)

Date

LIFESTYLE QUESTIONNAIRE

Lifestyle / Occupation

1. What hobbies do you enjoy? _____
2. What sports do you enjoy? _____
3. How many hours each day do you spend driving, either at daytime or nighttime? _____
4. Do you have interest in LASIK? _____
5. How many hours each day do you work on a computer? _____
6. Do you have headaches or eyestrain after working on a computer? _____
7. Do your eyes have a gritty or sandy feeling to them and do they burn? _____
8. Are your eyes dry? If so, do you use lubricating drops? _____

Eyewear

1. Are you satisfied with the way your glasses look and feel? _____
2. Are you satisfied with the vision and comfort of your glasses? _____
3. Do your glasses sometimes irritate your face or skin? _____
4. If your glasses were lost, could you function without them and do you have a second pair? _____
5. Are you bothered by the line if you wear bifocals or trifocals? _____
6. Do you have prescription sunglasses? _____
7. Do you need to tilt your head or find the "sweet spot" while doing computer work? _____
8. Are you bothered by glare or halos around lights? _____
9. Are you planning to get new glasses today? _____

Contact Lenses (if applicable)

1. Have you ever worn contact lenses? _____
2. How often do you wear contact lenses? _____
3. How many hours each day do you wear your contact lenses? _____
4. What is your brand of disinfecting solution? _____
5. If wearing disposable lenses, what is your actual replacement schedule? _____
6. Are you satisfied with the vision and comfort your contact lenses provide? _____