EyeStyle Profile

EMF PA NFP
Photo ID F/S
Dependent

Called by ______________________ **Follow Up**

Dilation Photos VF OCT Routine **CL Med GLS Dilation**

Interested in LASIK GLS CL Medical **Recheck__ Pressure CK___**

AR__ 2nd pair __ PL sun__ YR sply__ CL pts purch GLS__ GLS conv ratio__ CL conv ratio__

Dilated– return @ ________ Trials____________________________________

Order Trials____

Glasses $_____________

Old GL RE________________________ Voucher $____________

LE________________________ **Disp / Order _____ Box(s)** Contacts $____________

ADD______________ VIS Acc $_____________

Above for office use only Total $_____________

Please answer all of the following questions as accurately as you can. This questionnaire becomes part of your record and is confidential, and requires written authorization from you before it can be released to anyone else.

1. Please list all medications (including prescription drugs, birth control pills, over-the-counter drugs, vitamins, herbs, pain killers, antacids, etc.,) which you take, even if they are not taken every day.

Name of Drug/taken for	Dosage	# of times	How long taken	Prescribing Physician

2. (a) Please list any drugs you are allergic to ____
   (b) Please list any other allergies or hypersensitivities you have_______________________________

Do you have any of the following problems with your glasses?

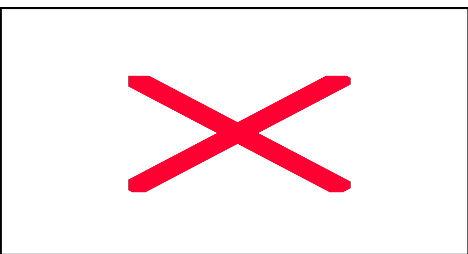
____Want new style
____Poor Fit
____Difficulty w/ Bifocals
____Glare
____Irritating under fluorescent lights
____Inadequate amount of reading area
____Need constant adjustment
____Outdated, faded, worn
____Scratched
____Screws fall out easily
____Heavy

Please Circle how often you currently wear the following forms of vision correction/protection.

Contact Lenses	Always	Often	Rarely	Never
Eyeglasses	Always	Often	Rarely	Never
Non-Prescription Sunglasses	Always	Often	Rarely	Never
Prescription Sunglasses	Always	Often	Rarely	Never

Please tell us how you use your eyes! Mark all that apply.

____Reading ____Computer ____Television ____Class Room ____Sewing ____Artist
____Musician ____Video Games ____Card Games ____Driving ____Cycling ____Golf
____Walking/Jogging ____Tennis ____Fishing ____Water Sports ____Snow Sports
Other____



Do you have any other specific visual needs? If so, please describe.
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