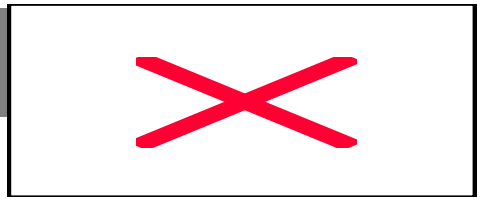
EyeStyle Profile

EMF PA Non Fees Pd UHC INS



RM# _____

CL Med GLS DFE IOP VF OCT REFRACT Photos TOPO PACH

GLS CL Medical LASIK

Trial: OD_____

OS_____

Dilation Photos VF

Dilated / AR return @ _____

ADD _____

JC RM CK *BC*

Old Glasses OD_____

OS _____

ADD_____

M1: OD _____

OS _____

Frames V2020 $_____

Lenses V2100 $_____

Contacts V2520 $_____

Vis Acc $_____

Occupational Health $_____

Please answer 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. Name you prefer to be called: Ms. Mrs. Mr. Dr. (Please circle one) _____
2. UGA Department / Area Of Study_____Occupation/ Type Of Work_____
3. 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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3.. (a) Please list any drugs you are allergic to _____

(b) Please list any other allergies or sensitivities you have_____

(c) Are you pregnant or could you be pregnant . Yes or No

(d) Please state time you ate . _____am or pm

(e) Do you have a history of fainting or feeling faint during a medical exam or procedure? Yes or No

Please Circle how often you currently wear the following :

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.

____Computer ____Artist ____Video Games

____Reading ____Musician ____Tennis

____Television ____Cycling ____Fishing

____Class Room ____Golf

____Sewing ____Walking/Jogging

____Driving ____Water Sports

____Snow Sports ____Card Games

Other_____

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

____Want new style

____Poor Fit

____Difficulty w/ Bifocals

____Glare

____Irritating under fluorescent light

____Inadequate amount of reading area

____Need constant adjustment

____Outdated, faded, worn

____Scratched

____Screws fall out easily

____Heavy

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

_____

_____