

Personal Information

Last Name: _____ First Name: _____ MI _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Home Ph# _____ Wrk Ph# _____ Member ID# _____
DOB: _____ Occupation: _____ Employer: _____
Emergency Contact Name: _____ Phone Number: _____
Date of Last Eye Exam: _____ Dilated? Yes/No _____
Today's Date: _____ Referred By: _____

Medical Information

What is your general health? _____
Do you have any of these problems? (Please circle yes or no.)
Gastrointestinal Yes/No Nervous Yes/No Endocrine (glands) Yes/No
Ears/Nose/Throat Yes/No Urinary Yes/No Blood/Lymph Yes/No
Cardiovascular Yes/No Muscles/Bones Yes/No Allergic/Immunologic Yes/No
Respiratory Yes/No Skin Yes/No Headaches Yes/No
High Blood Pressure Yes/No Eyes Yes/No Mental Yes/No
Please explain: _____
Diabetes Yes/No Type: _____ Date of Diagnosis: _____
Allergies to Medication? Yes/No Which? _____ Reactions: _____
Other health problems: _____
Current medication(s): _____ Check if none _____
Have you had any operations? Yes/No What kind? _____ When? _____
Name of Family doctor: _____ Phone Number: _____
Reason for Visit: Glasses? Yes/No Contacts? Yes/No Previous Wearer? Yes/No What Brand? _____

Family History

High Blood Pressure Yes/No Relation _____ Macular Degeneration Yes/No Relation _____
Diabetes Yes/No Relation _____ Retinal Detachment Yes/No Relation _____
Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____
Have you had any eye operations? Yes/No Type _____ Date: _____
Have you had an eye injury? Yes/No Kind _____ Date: _____
Do you have glaucoma? Yes/No Cataracts? Yes/No Dry Eyes? Yes/No
Macular Degeneration? Yes/No Retinal Detachment? Yes/No Blurred Vision? Yes/No
Do you wear Glasses? Yes/No Contact Lenses? Yes/No Type _____
Additional Information _____

This questionnaire is to be reviewed at each appointment. Please review all Questions.

Reviewed Date _____ Changes: Yes/No
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Doctor Use Only

Reviewed Date _____ Changes: Yes/No
Reviewed Date _____ Changes: Yes/No
Reviewed Date _____ Changes: Yes/No
Reviewed Date _____ Changes: Yes/No

I have read and understand the Miller Optical, Inc. HIPPA Notice of Privacy Practices.

Signature

Date