NAME_____
UGA ID#_____
DOB_____ GENDER_____

Patient Profile

Non Fees Pd

UNIVERSITY OF GEORGIA
University Health Center
Student Affairs

Please answer the following questions as accurately as you can.

- Name you prefer to be called: (Circle one) Ms. Mrs. Mr. Dr. _____
- UGA Department / Area of study _____ Occupation _____
- Reason for your visit today: _____
- Do you feel like your vision has changed? Y N _____How many years since last eye exam? _____
- List all medications (including prescription drugs, birth control pills, over-the-counter drugs, vitamins, herbs, pain killers, antacids, eye drops, etc.,) which you take, even if they are not taken every day. Please attach if a medication list is available.

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

- Drug allergies_____
- Environmental or material allergies: _____
- Are you pregnant or could you be pregnant? Yes or No
- Last time you ate. _____ am or pm
- Do you have a history of fainting or feeling faint during a medical exam or procedure? Yes or No

Do you wear the following?

Y N Contact Lenses
Y N Eyeglasses
Y N Non-Prescription Sunglasses
Y N Prescription Sunglasses

Contact lenses:

What brand of contacts do you wear? _____
What solution do you use? _____
Do you use any eye drops while wearing contact lenses? Y N
How often do you change your contacts? _____
How many hours do you wear your contacts each day? _____
How often do you sleep in your contacts? _____
Are you happy with your contact lenses? Y N

Circle any issues you have with your glasses.

Want new style	Constant adjustments
Poor Fit	Heavy
Difficulty with Bifocals	Difficulty reading
Glare	Outdated, faded, worn
Scratched	Other _____

Circle the activities that you participate in.

Computer	Artist	Video games
Reading	Musician	Tennis
TV	Cycling	Fishing
Class Room	Golf	Sewing
Driving	Water Sports	Snow Sports

Other _____

Below for office use only.

RM# _____ NP PP F/S
Insurance_____
GLS CL MED LASIK CAT PRE POST FLWUP
VF OCT PHOTOS TOPO PACH
DILATION IOP REFRACT

CC_____
BP_____ TEMP _____ PULSE_____
LE_____ NCT _____ /_____
VF Lens _____ /_____

CURRENT GLASSES
OD_____ 20/___
OS_____ 20/___
AGE_____ ADD_____ 20/___ OU 20/___

CURRENT CONTACTS
OD_____ 20/___
OS_____ 20/___
Brand_____ ADD_____ 20/___ OU 20/___

M1
OD_____ 20/___
OS_____ 20/___
ADD_____ 20/_____ OU 20/___

TRIAL
OD_____
OS_____
BRAND_____BC____ ADD____
Pricing ☐ Finalizing ☐

NOTES

☐ AR
☐ BP
☐ Diagnostic
☐ Referral

Contacts $_____

Reviewed: 2/22, 3/22
Revised: 1/19,