University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

Medical Profile

RM#_____ Dilated/AR return @ _____ EMF PA Non Fees Pd UHC INS

Old GL **OD**_____

OS_____ ADD_____

Above for office use only_____

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. 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 sensitiveness you have _____
   (c) Have you traveled abroad in the past 6 months ? Yes No If yes, where did you travel? _____
   (d) Are you pregnant or could you be pregnant ? Yes No
   (e) Please state time you last ate : _____am or pm
   (f) Do you have a history of fainting or feeling faint during a medical exam or procedure? Yes No

3. What is the reason for your visit today?_____
_____
_____
_____

4. Are you experiencing pain today? Yes No
5. How severe is the pain on a scale of 1-10, with 10 being the worst? 0 1 2 3 4 5 6 7 8 9 10
6. Have you had recent eye surgery? Yes No
7. Please explain any recent eye surgeries that you have had._____
_____

Date of 1st symptom: _____
Location:
Both eyes____ Right Eye____ Left Eye_____
How long have you had symptoms?
Hours_ __ Days_ __ Weeks_ __ Months____
Symptoms have gotten:
Better_____ Worse____ Same_____

Do you wear contact lenses? Yes No
Do you sleep in contact lenses? Yes No
Last time you slept in contact lenses?_____

Are you experiencing any of these symptoms? Please mark all that apply.

___Redness ___Floaters
___Double Vision ___Swelling
___Itching/Burning ___Headache/Pressure
___Dizziness ___Foreign Body
___Discharge ___Dry/Gritty
___Blurry Vision ___Light Sensitivity
___Flashes ___Other_____
_____