



Thank you for choosing Georgia Optometry Group. In order to give you the most complete eye exam possible please answer the following questionnaire.

PATIENT HISTORY FORM

Patient Name _____ F/M _____ Date Of Birth ___/___/___ Date _____
 Address _____ Apt. _____ Occupation: _____ Age _____
 City/ State _____ Zip _____ Home- () - _____
 Work- () - _____
 Cell- () - _____
 Email- _____

INSURANCE INFORMATION

Social Security Number _____ Vision Insurance Company _____
 Policy Holder's Name _____ Date of Birth ___/___/___ Medical Insurance Company _____
 Last medical exam date: ___/___/___ Doctor's Name: _____
 Last eye exam date: ___/___/___ Doctor's Name: _____

Please check any of the following that applies to you (if applies to a family member, use the appropriate initial, *M* -Mother, *F* -Father, *B* -Brother, *S* -Sister, *G* -Grandparent, *C* -Children):

- | | | | |
|---------------------------------|----------------------------------|-----------------------------------|-------------------------------|
| <i>Constitutional</i> | () Sandy or Gritty Feeling | <i>Respiratory</i> | <i>Lymphatic/ Hematologic</i> |
| () Fever, Weight loss/gain | () Itching | () Asthma | () Anemia |
| <i>Integumentary</i> | () Double Vision | () Chronic Bronchitis | () Bleeding Problems |
| () Skin Irritations | () Eye Injury | <i>Vascular/ Cardiac Vascular</i> | <i>Psychiatric</i> |
| <i>Neurological</i> | () Sties or Chalasion | () Diabetes for ___yrs. | () |
| () Headaches/ migraines | () Foreign Body Sensation | () Heart Disease | Immune System |
| () Seizures | () Excess Tearing/Watering | () High Cholesterol | () |
| <i>Eyes</i> | () Glare/ light sensitivity | () High Blood Pressure | () Cancer |
| () Loss of vision/side/central | () Eye Pain or Soreness | ()Vascular Disease | |
| () Macular Degeneration | () Flashes/ Floaters | <i>Gastrointestinal</i> | Pregnant Y or N |
| () Lazy Eye R/L | <i>Endocrine</i> | () Diarrhea | HIV Y or N |
| () Eye Surgery | () Thyroid Disease | () Constipation | |
| () Color Blindness | <i>Ears, Nose, Mouth, Throat</i> | <i>Genitourinary</i> | () Other |
| () Cataracts | () Sinus Congestion | () Genitals/ Kidney/ Bladder | |
| () Glaucoma | () Runny Nose | <i>Bones, Joints and Muscles</i> | |
| () Dryness | () Post-Nasal Drip | () Rheumatoid Arthritis | |
| () Mucus Discharge | () Chronic Cough | () Muscle/ Joint Pain | |
| () Redness | () Dry throat or Mouth | | |

List Current Medications: _____ List Allergies(Medical or environmental): _____

REASON FOR VISIT (Please Check)

- | | | |
|--|-------------------------------|--------------------------|
| _____ Blurred vision at distance/ near | _____ Headache or eye fatigue | _____ New eye glasses |
| _____ Broken or lost glasses | _____ Red eye | _____ New Contact lenses |
| | | _____ Other |

Glasses: Age of current pair _____ months/years
 Type:(circle) Single vision /Bifocal /Trifocal /Progressive
 Complications? _____

Contact Lenses: Last contact fitting date ___/___/___
 Type used: (circle) Soft disposable/ Soft daily wear/
 gas permeable/ extended wear
 Complications? _____

Would you like to discuss? (circle) Lasik / sport eyewear or contact lenses/ computer eyewear/ sun protective eyewear

Hobbies(circle) Golf / Fishing/ computers / woodworking/ reading/ music/ other _____

Who should we thank for referring you? _____

I have been notified of the availability of the Notice of Privacy Practices. Patients Initials: _____ Date: _____ Refused: _____

Signature _____ Reviewed / / / / / /