

# UCSD STUDENT HEALTH OPTOMETRY - PATIENT HISTORY QUESTIONNAIRE

(Must be updated at each visit)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Local Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Student ID# \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex: \_\_\_ Insurance: SHIP/Other \_\_\_\_\_ Email: \_\_\_\_\_  
Have you ever used our services before?  No  Yes:  Exam  Purchase  
Are you coming in for a contact lens prescription? Yes or No \_\_\_\_\_

The Optometry Department often utilizes the help of pre-optometry volunteers during the examination. If you do not want a volunteer assisting or observing with your examination, please initial \_\_\_\_\_.

Frames are often damaged when lenses are replaced. Therefore, please be advised the clinic is not responsible for any damage to your own frame or the new lenses during the lens replacement. Signature \_\_\_\_\_

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## MEDICAL INFORMATION

How is your general health? Poor/Fair/Good/Excellent \_\_\_\_\_

Do you have problems with any of these systems? (Check all that apply.)

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Gastrointestinal      | <input type="checkbox"/> Nervous              | <input type="checkbox"/> Eyes        |
| <input type="checkbox"/> Ears/Nose/Throat      | <input type="checkbox"/> Genitourinary        | <input type="checkbox"/> Mental      |
| <input type="checkbox"/> Cardiovascular        | <input type="checkbox"/> Musculoskeletal      | <input type="checkbox"/> Endocrine   |
| <input type="checkbox"/> Respiratory           | <input type="checkbox"/> Integumentary (Skin) | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Allergies/Immunologic |   |                                      |

Please explain: \_\_\_\_\_

Diabetes Y/N \_\_\_ Type: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Are you allergic to any medicine? Y/N \_\_\_ If yes, what type? \_\_\_\_\_ what happens? \_\_\_\_\_

Do you have other allergies? Y/N \_\_\_ If yes, to what? \_\_\_\_\_ what happens? \_\_\_\_\_

Headaches? Y/N \_\_\_ Other health problems? \_\_\_\_\_

Are you currently on any medication? Y/N \_\_\_ If yes, what medication are you on? \_\_\_\_\_

Have you had any operations? Y/N \_\_\_ If yes, what type of operation? \_\_\_\_\_

Do you use cigarettes /tobacco? \_\_\_\_\_ Alcohol? Y/N \_\_\_ Other substances: \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

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## FAMILY HISTORY

Who in your family has the following?

High Blood Pressure: \_\_\_\_\_ Macular Degeneration: \_\_\_\_\_ Diabetes: \_\_\_\_\_

Glaucoma: \_\_\_\_\_ Retinal Detachment: \_\_\_\_\_ Cataracts: \_\_\_\_\_

Other Eye Conditions Y/N \_\_\_ What? \_\_\_\_\_ Relation: \_\_\_\_\_

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## PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N \_\_\_ Type: \_\_\_\_\_ Date: \_\_\_\_\_

Have you had an eye injury? Y/N \_\_\_ Type: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have glaucoma? Y/N \_\_\_ Cataracts? Y/N \_\_\_ Dry Eyes? Y/N \_\_\_ Blurred Vision? Y/N \_\_\_

Flashes? Y/N \_\_\_ Floaters? Y/N \_\_\_ Halos? Y/N \_\_\_ Double Vision? Y/N \_\_\_

Other eye problems? Y/N \_\_\_ Please Explain \_\_\_\_\_

Do you wear glasses? Y/N \_\_\_ How old is the pair you are currently wearing? \_\_\_\_\_

Do you wear contact lenses? Y/N \_\_\_ Brand and Type? \_\_\_\_\_

What solution do you use? \_\_\_\_\_ How many days a week do you wear your contacts? \_\_\_\_\_

How many hours per day do you wear your contacts? \_\_\_\_\_ How often do you replace your lenses? \_\_\_\_\_

Do you sleep in your lenses? Y/N \_\_\_ If yes, how often? \_\_\_\_\_

Do you nap in your contacts? Y/N \_\_\_ If yes, how often? \_\_\_\_\_

Additional Information: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_