Must be updated at each visit

UC San Diego Student Health Service

Optometry Department

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Sex:** □ **M** □ **F** **Date:** _____

Phone: (____) _____ **Emergency Contact:** (_____) _____ **Student ID #:** _____ **Email:** _____

Insurance: □ **SHIP** □ **Other** _____ **Have you ever used our services before?** □ **No** □ **Yes:** □ **Exam** □ **Purchase**

The clinic utilizes pre-optometry volunteers. If you do not want a volunteer assisting or observing your examination, please initial here: _____

Are you coming in for a contact lens prescription? □ **Yes** □ **No** **Date of last eye exam:** _____

MEDICAL INFORMATION

What is your general health? □ Poor □ Fair □ Good □ Excellent

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

□ Gastrointestinal □ Nervous □ Eyes □ Respiratory
□ Ears/Nose/Throat □ Genitourinary □ Mental □ Integumentary (Skin)
□ Cardiovascular □ Musculoskeletal □ Endocrine □ Blood/Lymph
□ Allergies/Immunologic

Explain: _____

Check all that apply:	Y	N	Explain (include type & date of diagnosis if applicable)
Diabetes			
Allergies			
Medication Allergy			
Headaches			
Medication			
Operations			
Cigarette/Tobacco use			
Alcohol			

Name of Family Doctor: _____ Approximate Date of Last Visit: _____

FAMILY HISTORY

Check all that apply:	Y	N	Who in your family has had the following?
High Blood Pressure			
Macular Degeneration			
Diabetes			
Cancer			
Glaucoma			
Retinal Detachment			
Other Eye Conditions			Type:

PERSONAL EYE INFORMATION

Check all that apply:	Y	N	Explain (include type & date if applicable)
Eye Operations			
Eye Injury			
Dry Eyes			
Blurred Vision			
Flashes			
Floaters			
Halos			
Double Vision			
Other Eye Problems			
Glasses			
Contact Lens			Brand: Solution: How many days a week do you wear your contacts? _____ Hours per day? _____ Do you sleep in your lenses? Yes or No How often? _____ Do you nap in your contacts? Yes or No How often? _____

Additional Information: _____