Marshall B.
KETCHUM UNIVERSITY
Southern California College of Optometry
University Eye Center at Los Angeles

PRIMARY EYE CARE SERVICE HEALTH HISTORY & LIFESTYLE QUESTIONNAIRE

Welcome to the University Eye Center at Los Angeles! Please complete the following questions. Thank you.

Patient Name ____________________________ Birth date: ____________ Gender: M or F Date: ___/____/____

Primary Care Physician / Location: ______________________________ Date of last Physical Exam: ________ Height____ Weight___

EYE Doctor/Location: ____ Date of last EYE exam. ___________________

PREFERRED Pharmacy/Location____

Occupation / Type of work you do: ____

What specific job related vision needs should we know about: ____

What is the **main reason** for your visit today? ____

SPECTACLE / CONTACT LENSES

Do you presently wear glasses? **NO YES**: Full-Time / Part Time Distance only Reading only Computer

Do you presently wear contact lenses? **NO YES**: Do you wish to update the prescription? **YES NO**

Would you like to see if you are a good candidate for the latest contact lens designs? **YES NO**

Would you like to discuss laser refractive surgery options today? **YES NO**

COMPUTER USE

Do you use a computer? At work___: Hours/Day____ At home ______: Hours/Day___

Circle any of the following symptoms that you experience while using your computer:

Tired eyes	Dry eyes	Headaches
Blurred vision	Double Vision	Red eyes

Do you use special computer glasses? **YES NO**

Are you interested in designated glasses to make computer work easier? **YES NO**

SPORTS AND LEISURE

What sports do you participate in? ____

Do you wear contact lenses or any special eyewear for your sport? ____

In what recreational activities do you participate? ____

What hobbies do you have? ____

EYE / VISION PROBLEMS

Circle all that apply.

Blurry vision	With Glasses	Without Glasses	Eye Turn In/Out	Lumps
Loss of vision			Loss of Field of Vision	Eye Pain
Abrasion			Floaters/Flashes	Red Eye
Eye Allergy/Itchy Eyes			Foreign Body Sensation	Trauma/Burn
Double Vision			Headache/Migraine	

Any other visual symptoms or eye problems not listed above?

____

____

EYE HISTORY

Amblyopia (lazy eye)	Me	Family	Macular Degeneration	Me	Family
Blindness	Me	Family	Retinal Detachment	Me	Family
Cataracts	Me	Family	Strabismus (eye turn)	Me	Family
Color Deficiency	Me	Family	Eye Injury	Me	Family
Glaucoma	Me	Family	Surgery	Me	Family

Any other eye / vision problems (other than glasses)

____

____

MEDICAL HISTORY

Currently pregnant or nursing ___ Yes __ No

AIDS / HIV Positive	Me		Diabetes	Me	Family	Multiple Sclerosis	Me	Family
Allergic Disorders	Me	Family	Head Trauma	Me	Family	Respiratory Disorder	Me	Family
Arthritis	Me	Family	Heart	Me	Family	Stroke	Me	Family
Cancer	Me	Family	Hypertension	Me	Family	Thyroid Disease	Me	Family
Cholesterol, elevated	Me	Family	Migraines	Me	Family			

Do you have any other health problems other than those circled above?

____

SURGICAL HISTORY List any surgeries you have undergone.

____

EYE SURGERY List which eye, type of surgery, and date.

____

EYE MEDICATIONS or EYE DROPS (including over the counter)

____

SYSTEMIC MEDICATIONS

_____**NO** Medications or Supplements Taken ______**Yes**: Please list all current medications and supplements.

____

____

____

MEDICATION ALLERGY / SIDE EFFECTS List medications and the side-effect

____

____

____

SOCIAL HISTORY Information strictly confidential. Can be discussed privately with your doctor if you wish.

Tobacco Use Alcohol Use Narcotic Use Sexually Transmitted Diseases Blood Transfusions.

Other.____

____

Please turn over