KETCHUM HEALTH
University Eye Center

HEALTH HISTORY FORM & LIFESTYLE QUESTIONNAIRE

WELCOME TO THE UNIVERSITY EYE CENTER! PLEASE COMPLETE THE FOLLOWING:

Patient Name: _____ Date of Birth _____ / _____/ _____

Today's Date _____ / _____ / _____

Gender: ☐ Male ☐ Female Height: _____ ft _____ in Weight:_____ lbs

Last EYE Doctor/Location: _____ Date of last EYE exam: _____

Primary Care Physician/ Location: _____

Date of last PHYSICAL Exam: _____

Pharmacy/Location_____ Occupation: _____

What is the **MAIN reason** for your visit today? _____

Do you have any other visual/ocular problems? _____

SPECTACLE/CONTACT LENSES

Do you wear glasses? ☐ Yes ☐ No ☐ Full Time ☐ Part Time ☐ Distance Only ☐ Reading Only ☐ Multifocal

How old are your current glasses? _____ Do you wear contact lenses? ☐Yes ☐No

Are you interested in a new contact lens design? ☐ Yes ☐ No

Are you interested in refractive surgery (laser or cataract) options? ☐ Yes ☐ No

COMPUTER USE How many total hours per day do you use a computer, cell phone, tablet or play video games?

☐ 0-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ more than 6 hours

Do you use computer glasses? ☐ Yes ☐ No Are you interested in special glasses to make computer work easier? ☐ Yes

SPORTS AND LEISURE : What sports/hobbies do you participate in? _____

Do you wear any special eyewear for your sport/hobby? _____

Do you currently wear prescription sunglasses? ☐ Yes ☐ No Are you sensitive to bright lights? ☐ Yes ☐ No

DRY EYE QUESTIONNAIRE Please check off the following or **FREQUENCY** and **SEVERITY** of dry eye symptoms:

FREQUENCY of Symptoms	0	1	2	3
Dryness, grittiness or scratchiness				
Soreness or irritation				
Burning or watering				
Eye fatigue				

SEVERITY of Symptoms	0	1	2	3	4
Dryness, grittiness or scratchiness					
Soreness or irritation					
Burning or watering					
Eye fatigue					

0: Never
1: Sometimes
2: Often
3: Constant

0: No problems
1: Tolerable (not perfect, but not uncomfortable)
2: Uncomfortable (irritating, but does not interfere with my day)
3: Bothersome (Irritating and interferes with my day)
4: Intolerable (unable to perform my daily tasks)

Office Use Only

Intern Initials_____

Faculty Initials _____

Please turn over →

PLEASE CHECK ONLY THOSE BOXES THAT APPLY. UNCHECKED BOXES WILL MEAN "NO".

☐ **Please check here if all of review of systems is NO.**

☐ **Please check here if all of the following is NO.**

Review of Systems

	Current Symptoms	**Yes**
Allergy	Seasonal	
	Penicillin	
	Sulfa	
	Neomycin	
	Anesthetic or "Caine" drug	
	Food:	
	Other:	
Constitutional	Unexplained Fever	
	Unexplained Weight Loss	
	Unexplained Fatigue	
Cardiovascular	Chest pain	
	Shortness of breath with exertion	
	Irregular heart beat	
	Low heart rate	
Endocrine	Increase in urination	
	Increase in thirst	
	Increase in appetite	
Gastrointestinal	Constipation	
	Diarrhea	
	Unexplained abdominal pain	
	Vomiting blood	
	Blood in stool	
Genitourinary	Burning while urinating	
	Difficulty urinating	
	Blood in urine	
Head	Persistent sore throat	
	Hearing loss	
	Hoarseness of voice	
	Ear or nose discharge	
	Loss of smell	
	Sinus congestion	
	Difficulty swallowing	
	Mouth ulcers	
Hematologic/	Swollen glands	
Lymphatic	Anemia	
	Frequent bruising	
Immunologic/	History of infectious disease	
Integumentary	Unexplained skin rashes	
(Skin)	Persistent itching of skin	
	Eczema of skin	
	Pigmented lesions	
Musculoskeletal	Joint pain	
	Unexplained muscle pain	
	Restriction of motion	
	Lower back pain	
Neurologic	Muscle weakness	
	Tingling in extremities	
	Dizziness	
	Blackouts/Grey outs	
Psychiatric	Ongoing depression	
	Memory lapses	
	Disorientation	
	Dementia	
Respiratory	Shortness of breath	
	Persistent cough	
	Wheezing sounds	

EYE HISTORY			
Conditions	**Yes**	***Surgeries***	**Yes**
Glaucoma/ Suspect		Cataract	
Cataract		Glaucoma	
Macular degeneration		Retinal Detachment	
Uveitis		LASIK	
Retinal Detachment		Laser	
Eye turn/Lazy Eye		Eyelid	
Trauma		Injections in the eye	
Other:		Other:	
Medical History			
	Yes		**Yes**
Diabetes		Heart Attack	
High blood pressure		Stroke	
Elevated Cholesterol		Cancer	
Thyroid disorder		Asthma/COPD	
Sleep Apnea		Kidney disease	
Pregnant - currently		Arthritis	
Nursing- currently		Other:	
Family History			
Ocular	***Yes***	***Medical***	**Yes**
Glaucoma		Diabetes	
Macular degeneration		Hypertension	
Eye turn		Cancer	
Night blindness		Heart disease	
Keratoconus		Migraine	
Other:		Other:	
Social History			
	Yes		**Yes**
Smoked in the past		Drink alcohol	
Currently smoke		Recreational drug use	

***Medications:** Please include over the counter medications, eye drops, vitamins, contraceptives, and herbal supplements*

Name	Dose	Purpose

Update: I verify that the information contained on this page is current and without changes. Signature required yearly.

_____

Patient Signature Date