SWARTZ FAMILY EYECARE, LLC
HEALTH AND VISION HISTORY FORM

Patient's Full Name: _____ **DOB:** ___/___/___ **Date:**_____

Marital Status: S M W D Employer:_____ **Occupation:**_____

Hobbies:_____ **Last Eye Exam:**_____

Do any BLOOD RELATIVES (Grandparent, Parent, Sibling, or Child) have any of the following conditions? (Please Circle)

Cancer	**Arthritis**	**Amblyopia (Lazy Eye)**	**Cataract**
Diabetes	**Lupus**	**Eye Turn(s)**	**Glaucoma**
Heart Disease	**Migraines**	**Eye Tumor**	**Macular Degeneration**
High Blood Pressure			**Other**_____

Primary Care Physician: _____

Are you currently receiving treatment from a physician? Yes No

If Yes, Please Explain: _____

Have you recently had any illness? Yes No If Yes: _____

(Women) Are you pregnant or nursing? Yes No

Are you presently taking or using any medication? Yes No

If yes: (Please include dosage on medication) _____

_____

_____

Please list any eye surgeries or injuries: _____

_____

Do you use any of the following products?

Alcohol? Yes No

Tobacco? Yes No

Former Smoker? Yes No

Recreational Drugs? Yes No

Please indicate your race (optional):

White Black/African American Asian

American Indian Hispanic/Latino Other

Preferred Language? _____

Eyewear Assessment :

Are you interested in contact lenses? Yes No

Do you wear glasses? Yes No

How many hours per day do you spend on a computer or digital device? _____

Do you have headaches/eyestrain during or after computer/digital device use? Yes No

Do you experience:

Blurred vision? Yes No **Night driving difficulty?** Yes No

Glare or halos around lights? Yes No **Double vision?** Yes No

Sensitivity to light? Yes No **Flashes or floaters?** Yes No

Headaches? Yes No **Redness, itching, watering, aching, burning, or dryness?** Yes No

Please circle if you have a (please circle): brother sister son daughter.

Please list any major injuries/surgeries:_____

_____

Do you have/had a problem with or are being treated for the following?
Please circle Yes or No and use the box to provide additional information, if necessary.

Constitution			**Cardiovascular**			**Musculoskeletal**		
Cancer	Yes	No	Congestive Heart Failure	Yes	No	Arthritis	Yes	No
Developmental Disabilities	Yes	No	Heart Disease	Yes	No	Ankylosing Spondylitis	Yes	No
Fatigue Syndrome	Yes	No	Hypertension	Yes	No	Fibromyalgia	Yes	No
Other	Yes	No	Other	Yes	No	Gout	Yes	No
ENT			**Respiratory**			Osteoporosis	Yes	No
Laryngitis	Yes	No	Asthma	Yes	No	Muscular Dystrophy	Yes	No
Hearing Loss	Yes	No	Emphysema	Yes	No	Osteoarthritis	Yes	No
Dry Mouth	Yes	No	Chronic Obstruction	Yes	No	Other	Yes	No
Sinusitis	Yes	No	Bronchitis	Yes	No	**Integumentary**		
Other	Yes	No	Sleep Apnea	Yes	No	Cold Sores	Yes	No
Neuro			Other	Yes	No	Eczema	Yes	No
Epilepsy	Yes	No	**Gastrointestinal**			Psoriasis	Yes	No
Tumor	Yes	No	Celiac Disease	Yes	No	Rosacea	Yes	No
Cerebral Palsy	Yes	No	Ulcer	Yes	No	Shingles	Yes	No
Migraine	Yes	No	Colitis	Yes	No	Other	Yes	No
Multiple Sclerosis	Yes	No	Acid Reflux	Yes	No	**Endocrine**		
Stroke/CVA	Yes	No	Crohn's Disease	Yes	No	Diabetes Type I	Yes	No
Other	Yes	No	Other	Yes	No	Non-Insulin Insulin (Circle)	Yes	No
Psych			**Genitourinary**			Diabetes Type II	Yes	No
Depression	Yes	No	Pregnant	Yes	No	Non-Insulin Insulin (Circle)	Yes	No
Anxiety Disorder	Yes	No	Nursing	Yes	No	Hormonal Dysfunction	Yes	No
Bipolar Disorder	Yes	No	Kidney Disease	Yes	No	Thyroid Dysfunction	Yes	No
Attention Deficit	Yes	No	Prostate Disease/Cancer	Yes	No	Other	Yes	No
Other	Yes	No	Benign Prostate Hypertrophy	Yes	No	**Hematologic/Lymphatic**		
Allergy/Immunoligic			STD	Yes	No	Anemia	Yes	No
Sjogren's Syndrome	Yes	No	Other	Yes	No	Large-Volume Blood Loss	Yes	No
Rheumatoid Arthritis	Yes	No	**Other/Addition Information:**			High Cholesterol	Yes	No
Lupus	Yes	No				Other	Yes	No
Drug Allergies (Please List)	Yes	No						
Environmental Allergies	Yes	No						
	Yes	No						

If you are a new patient, whom may we thank for referring you to us?

Primary Care Physician Yellow Pages Website Insurance Plan

Current Patient: _____