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 ____________________________

Does any **blood relative** (Grandparent, Parent, Sibling, or Child) have any of the following conditions? (Please Circle)

Amblyopia (Lazy Eye)	Arthritis	Cancer	Cataract
Diabetes	Eye Tumor	Eye Turn(s)	Glaucoma
Heart Disease	Hypertension	Lupus	Macular Degeneration
Migraines	Retinal Detachment	Thyroid	Other____________

Are you currently receiving treatment from a physician? ☐ Yes ☐ No If Yes: ____________________

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)

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____

____

Please list any eye surgeries or injuries

____

Do you use any of the following products? Please indicate your race (optional):

Alcohol? ☐ Yes ☐ No White Black/African American Asian

Tobacco? ☐ Yes ☐ No American Indian Hispanic/Latino Other

Former Smoker? ☐ Yes ☐ No

Recreational Drugs? ☐ Yes ☐ No Preferred Language? _______________________

Eyewear Assessment

Do you currently wear glasses? ☐ Yes ☐ No If Yes, When? ___________________________

If yes, how often? ☐ All the time? ☐ For reading only? ☐ For Computer only? ☐ For Distance only?

Do you currently wear contact lenses? ☐ Yes ☐ No

How often do you replace your contact lenses? ______________________

What is your average contact lens wearing time per day? ______________

What brand of contact lenses are you wearing? ______________________

What is your current cleaning solution? ____________________________

Do you sleep in your contact lenses? ☐ Yes ☐ No ☐ Rarely

If no, are you interested in contact lenses? ☐ 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 check if you have a ☐ brother ☐ sister ☐ son ☐ daughter.

Name of your Primary Care Physician___________________________________

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)		
Psych			**Genitourinary**			Diabetes Type II	Yes	No
Depression	Yes	No	Pregnant	Yes	No	Non-Insulin Insulin (Circle)		
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				Ulcer	Yes	No
Drug Allergies	Yes	No				Other	Yes	No
Environmental Allergies	Yes	No						
Other	Yes	No						

Please list any major injuries or surgeries. ____
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If you are a new patient, whom may we thank for referring you to us?

□ Insurance Plan □ Current Patient: ____

□ Primary Care Physician □ Yellow Pages □ Website □ Other ______________________