SWARTZ FAMILY EYECARE, LLC
HEALTH AND VISION HISTORY FORM

Patient's Full Name: _____ **DOB:** ____/____/____ **Date:** _____
Marital Status: S M W D **Sex:** Male Female **Gender:** Male Female Other: _____
Please indicate your race (optional): **Preferred Language:** _____
White Black/African American Asian **Employer:** _____
American Indian Hispanic/Latino Other **Occupation:** _____
Hobbies: _____ **Date of Last Eye Exam (if not here):** _____
Do any BLOOD RELATIVES (Grandparent, Parent, Sibling, or Child) have any of the following conditions? (Please Circle)
Cancer Heart Disease Arthritis Hypertension Eye Turn(s) Cataract Macular Degeneration
Diabetes Migraines Lupus Amblyopia (Lazy Eye) Eye Tumor Glaucoma 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 name and dosage)** ____
_____
_____
_____
Do you have any DRUG ALLERGIES? Yes No **If Yes:** _____
Have you had any eye surgeries, eye injuries, eye diseases, or eye disorders? Yes No **If Yes:** _____
_____
_____

<u>Do you use any of the following products?</u>
Alcohol? Yes No **Tobacco?** Yes No **Former Smoker?** Yes No **Recreational Drugs?** Yes No

<u>Eyewear Assessment:</u>
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

<u>Do you experience:</u>
Blurred vision? Yes No
Glare or halos around lights? Yes No
Sensitivity to light? Yes No
Headaches? Yes No
Night driving difficulty? Yes No
Double vision? Yes No
Flashes or floaters? Yes No
Redness, itching, watering, aching, burning, or dryness? Yes No

Have you had any major injuries or surgeries? Yes No **If Yes:** _____

_____

_____

Do **you** have a problem with or are you being treated for the following (currently or in the past)? Please circle Yes or No and use the box to provide additional information, if necessary.

Constitution		
Cancer	Yes	No
Developmental Disabilities	Yes	No
Fatigue Syndrome	Yes	No
Other	Yes	No
ENT		
Dry Mouth	Yes	No
Hearing Loss	Yes	No
Laryngitis	Yes	No
Sinusitis	Yes	No
Other	Yes	No
Neurological		
Cerebral Palsy	Yes	No
Epilepsy	Yes	No
Migraine	Yes	No
Multiple Sclerosis	Yes	No
Stroke/CVA	Yes	No
Tumor	Yes	No
Other	Yes	No
Psychological		
Anxiety Disorder	Yes	No
Attention Deficit	Yes	No
Bipolar	Yes	No
Depression	Yes	No
Other	Yes	No
Allergy/Immunologic		
Lupus	Yes	No
Sjogren's Syndrome	Yes	No
Environmental Allergies	Yes	No
Other	Yes	No

Cardiovascular		
AFib	Yes	No
Congestive Heart Failure	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Other	Yes	No
Respiratory		
Asthma	Yes	No
Bronchitis	Yes	No
Chronic Obstruction	Yes	No
Emphysema	Yes	No
Sleep Apnea	Yes	No
Other	Yes	No
Gastrointestinal		
Acid Reflux	Yes	No
Celiac Disease	Yes	No
Colitis	Yes	No
Crohn's Disease	Yes	No
Irritable Bowel (IBS)	Yes	No
Ulcer	Yes	No
Other	Yes	No
Genitourinary		
Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Benign Prostate Disease	Yes	No
Prostate Cancer	Yes	No
Kidney Disease	Yes	No
Other	Yes	No

Musculoskeletal		
Ankylosing Spondylitis	Yes	No
Arthritis	Yes	No
Fibromyalgia	Yes	No
Gout	Yes	No
Muscular Dystrophy	Yes	No
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Other	Yes	No
Integumentary (Skin)		
Cold Sores	Yes	No
Eczema	Yes	No
Psoriasis	Yes	No
Rosacea	Yes	No
Shingles	Yes	No
Other	Yes	No
Endocrine		
Diabetes Type I	Yes	No
(Circle) Non-Insulin Insulin		
Diabetes Type II	Yes	No
(Circle) Non-Insulin Insulin		
Hormonal Dysfunction	Yes	No
Thyroid Disease	Yes	No
Other	Yes	No
Hematologic		
Anemia	Yes	No
High Cholesterol	Yes	No
Large Volume Blood Loss	Yes	No
Other	Yes	No

Other/Additional Information: