Dr. Jackie L. Schwartz
Independent Doctor of Optometry at World Eyeglasses

PATIENT HEALTH INFORMATION SHEET

EYE HISTORY

Date of Last Eye Exam: _____

Currently Wear Glasses? _____

Currently Wear Contact? _____

Reason for Today's Visit: _____

Have you or a family member experienced, or been treated for any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
Lasik or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have you experienced any of the following? Select all that apply.

- ◯ Blurry Vision Near | Distance
- ◯ Burning
- ◯ Discharge
- ◯ Double Vision
- ◯ Dryness
- ◯ Excess Tearing/Watering
- ◯ Eye Infection
- ◯ Floaters or Spots
- ◯ Halos
- ◯ Headaches
- ◯ Itching
- ◯ Light Flashes
- ◯ Light Sensitivity
- ◯ Redness
- ◯ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications ◯ **I take no medications**
(prescription and over-the-counter and dosage)

Medication Drug Allergies ◯ **I have no Drug Allergies**

Surgeries ◯ **I have had no Surgeries**

Are you pregnant or nursing? ◯ Yes ◯ No **Do you smoke?** ◯ Yes ◯ No **Have you ever smoked?** ◯ Yes ◯ No

What hobbies do you enjoy? _____

When do glare and bright lights bother you? ◯ On-coming headlights ◯ Computer Screen ◯ Glare from windshield ◯ Sunlight

Do you use a Computer for more than 2 hours a day? ◯ Yes ◯ No

When working on a computer do you experience any of the following? ◯ Eye Strain / Tired Eyes ◯ Headaches