REVIEW OF SYMPTOMS (Please check *ALL* that apply)

Constitution
❑ Developmental Disabilities ❑ Fatigue Syndrome
❑ Cancer Other ______________________________

ENT
❑ Hearing Loss ❑ Sinusitis ❑ Laryngitis
❑ Laryngitis ❑ Other ___________________________

Neurological
❑ Multiple Sclerosis ❑ Epilepsy ❑ Cerebral Palsy
❑ Autism Spectrum ❑ Stroke/CVA ❑ Migraine
❑ Tumor ❑ Other __________________________

Psychiatric
❑ Depression ❑ Attention Deficit ❑ Anxiety Disorder
❑ Bipolar Disorder ❑ Other ____________________

Cardiovascular
❑ Hypertension ❑ Heart Disease ❑ Vascular Disease
❑ Congestive Heart Failure ❑ Other ______________

Respiratory
❑ Emphysema ❑ Asthma ❑ Bronchitis ❑Sleep Apnea
❑ Chronic Obstruction ❑ Cigarette Smoker

Gastrointestinal
❑ Crohn's ❑ Colitis ❑ Ulcer ❑ Acid Reflux
❑ Celiac Disease ❑ Other _______________________

Genitourinary
❑ Kidney Disease ❑ Prostate Disease/Cancer ❑ Herpes
❑ Chlamydia ❑ Benign Prostate Hypertrophy
❑ Pregnant ❑ Nursing ❑ Other _______________

Musculoskeletal
❑ Arthritis ❑ Osteoarthritis ❑ Fibromyalgia ❑ Gout
❑ Muscular Dystrophy ❑ Ankylosing Spondylitis
❑ Osteoporosis ❑ Other _______________________

Integumentary
❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Cold Sores
❑ Shingles ❑ Other ____________________________

Endocrine
❑ Diabetes Type 2 ❑ Diabetes Type 1
❑ Thyroid Dysfunction ❑ Hormonal Dysfunction
❑ Other ______________________________________

Hemotologic/Lymphatic
❑ Anemia ❑ Blood Loss ❑ High Cholesterol
❑ Other _______________________________________

Allergic/Immune
❑ Environmental/Seasonal Allergies ❑ Lupus
❑Rheumatoid Arthritis ❑ Sjogren's Syndrome
❑ Other ______________________________________

Please list all *MEDICATIONS*:

____

____

Please list all *ALLERGIES*:

____

____

Past Ocular History (check all that apply):

❑ Glaucoma Suspect ❑ Glaucoma ❑ Cataract
❑ Macular Degeneration ❑ Surgery ❑ Patching
❑ Inflammatory Disorder ❑ Strabismus ❑ Amblyopia
❑ Retinal Degeneration ❑ Retinal Hole
❑ Retinal Detachment ❑ Keratoconus ❑ Injury
❑ Dry Eye ❑ Nystagmus ❑ Other_______________

Social History:

Drinking: ❑ Yes ❑ No Frequency: _________________
Smoking: ❑ Yes, ❑ Everyday ❑ Occasional ❑ Rare
❑ No, ❑ Never ❑ Former Smoker
Type: ❑ Cigarettes ❑ Cigars ❑Pipe ❑ E-Cig
❑ Other_____________________________

Family History:

Please list any immediate family members;
i.e. mother, father, brother, sister, son, daughter

❑ Diabetes Type 1 _______________________________
❑ Diabetes Type 2 _______________________________
❑ Hypertension __________________________________
❑ Malignant Melanoma_____________________________
❑ Cataracts______________________________________
❑ Blindness______________________________________
❑ Macular Degeneration ___________________________
❑ Glaucoma ______________________________________
❑ Retinal Detachment ______________________________

Payment is required when services are rendered and deposits are required on all eyeglasses and contact lenses ordered. I hereby authorize Dr. Arlene Schwartz to release to insurance carriers any information concerning my condition and treatments. I understand the Hartsdale Family Eyecare submits to my insurance as a courtesy, and I accept full responsibility for any deductibles, co-insurance, and/or non-covered services. The insurance information furnished here represents a full disclosure of the Insurance/Third Party benefits to which I am entitled. I also request payment of government/medical benefits either to myself or to the Party for services rendered.

Signature____ Date___________________________