VISION AND HEALTH HISTORY

Appointment Date:_____

Name: _____**Date of Birth**_____

Address: _____**City**_____**Postal Code**_____

Phone number: _____ *** Email Address:**_____

Vision Care Insurance: YES/NO Insurance Company Name:_____

When was your last eye examination? _____ Examiner: _____

Have you ever worn prescription glasses? Yes ____ No ____ Age of current glasses _____

Do you have prescription sunglasses? Yes ____ No ____

Does your driver's license require glasses to drive? Yes _____ No_____ Class of driver's license? _____

Have you ever worn contact lenses? Yes ____ No ____ Are you interested in Contact Lenses? Yes ____ No ____

Occupation: _____ Hobbies: _____

How many hours a day do you spend using a digital device? _____

	Self		Family History		OTHER EYE CONDITIONS/EYE CONCERNS
Eye Surgery/Eye Injuries	Yes	No	Yes	No	
Eye Turn	Yes	No	Yes	No	
Cataract	Yes	No	Yes	No	
Glaucoma	Yes	No	Yes	No	
Retinal detachment/Retinal Issues	Yes	No	Yes	No	
Macular Degeneration	Yes	No	Yes	No	

Family Doctor's Name & Phone Number: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?	Self		OTHER MEDICAL ISSUES
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Diabetes TYPE 1 or TYPE 2 (circle) A1c _____	Yes	No	
Arthritis OSTEOARTHRITIS or RHEUMATOID (circle)	Yes	No	
Thyroid Disease	Yes	No	
PREGNANT or NURSING	Yes	No	

Do you have any allergies to medications:_____

List Medications & Vitamins: _____

_____

Are you a smoker? Yes ___ No ___ How long have you been a smoker?_____ Pack(s) Per Day_____

Are you a former smoker? Yes ____ No____ When did you quit? Month _____ Year _____

Please tell us how you were referred to this office: _____

*By providing your email, you consent to receive email from Midland Eyecare.