VISION AND HEALTH HISTORY

Appointment Date: _____

MIDLAND EYECARE

Name: _____ **Date of Birth:** _____

Gender: _____ **Preferred Pronouns:** _____ **Phone number:** _____

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

*** Email Address:** _____ **Vision Care Insurance:** ☐ **Yes** ☐ **No**

Insurance Company Name (If Applicable): _____ **Policy #:** _____ **Member ID #** _____

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** ◯ **TYPE 2** **A1c**_____	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Arthritis ◯ **OSTEOARTHRITIS** ◯ **RHEUMATOID**	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Currently PREGNANT or NURSING (If Applicable)	☐ 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.