INTERIM MEDICAL HISTORY

Name _____ Date _____
Date of Birth _____ Date of last eye exam _____

Are you on any **new medications** (Rx & OTC) since your last visit?

_____

Do you have any **new allergies** to medications since your last visit?

_____

Have you had any **major illnesses** or **injuries** since your last visit?

_____

Have you had any **surgeries** since your last visit?

_____

Do you currently have any problems in the following areas? If "YES" please provide information.

	YES	NO	Explanation of Problem
Eyes			
General/Constitutional (headaches, cancer, AIDS)			
Ear, Nose, Throat (sinus, chronic cough, dry mouth)			
Cardiovascular (heart, vessels, high blood pressure)			
Respiratory (asthma, emphysema)			
Gastrointestinal (stomach ulcers, intestinal disease)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (arthritis, osteoporosis)			
Skin (acne, warts, Skin cancer)			
Neurological (multiple sclerosis, stroke, TIA)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, thyroid)			
Blood, Lymph (cholesterol, anemia)			
Allergic, Immunologic (hay fever, lupus)			

Social

Changes in employment? _____
Marital status (married, divorced, single, widowed) _____
Do you drive? ☐Yes ☐No
Do you have visual difficulty when driving? ☐Yes ☐No
Do you have problems with night vision? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No If Yes: occasional 1 per day 2-3/day 4+/day
Do you smoke? ☐Yes ☐No If Yes: occasional ½ pack/day 1pack/day 1+Pack/day

Patient Signature: _____

Physician Signature: _____