Ronit Kahanowicz, MD

INTERIM MEDICAL HISTORY

Name: _____ Date of Birth: _____ Date: _____

Date of **last eye exam** (with complete medical history) _____

What new medications do you currently take (prescription and over the counter)

(cite exam where most recent complete list of meds is documented) _____

Do you have new allergies to any medications, since your last visit? YES NO

If YES, list the medications: _____

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	Details
EYES (blur, glare, red, pain, etc.)			
GENERAL / CONSTITUTIONAL (fever, weight loss, etc.)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (high cholesterol, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

Any changes to family medical status (mother, father, sibling, grandparent)? **YES** **NO**

IF Yes, please describe: _____

SOCIAL HISTORY

Changes in employment: _____

Changes in marital status: _____

Changes in living arrangements: _____

Changes in driving habits _____

Do you drink alcohol?	**YES**	**NO**	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	**YES**	**NO**	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: _____ *Date:* _____