INTERIM MEDICAL HISTORY

Date_____

Name_____ Date of **last eye exam**_____

What ***new*** **medications** (Rx & OTC) do you currently take?

Do you have any ***new*** **allergies** to 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 you 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			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD, LYMPH			
ALLERGIC, IMMUNOLOGIC			

FAMILY
Any changes to family medical status (mother, father, sibling, grandparent)? _____YES _____NO
If YES, describe_____

SOCIAL
Changes in employment?_____
Marital Status (married, divorced, single, widowed)_____
Living arrangements_____
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 1 pack/day 1+ pack

Physician's Signature_____