

INTERIM MEDICAL HISTORY

Date _____

Name _____ Date of last eye exam _____
With complete medical history

What new medications (RX & OTC) do you currently take: (site exam where most recent complete list of Meds is documented)

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*? YES NO

Have you had any surgeries *since your last visit*? YES NO

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 drink alcohol? Yes No If Yes: occasional 1 per day 2-3 per day 4+ per day

Do you smoke? Yes No If Yes: occasional ½ pack/day 1 pack/day 1+ pack/day

Physician's Signature: _____