

INTERIM MEDICAL HISTORY

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, injuries or surgeries *since your last visit*?

Do you *currently* have any problems in the following areas?

| | YES | NO | EXPLANATION OF PROBLEM |
|------------------------------------|-----|----|------------------------|
| EYES | | | |
| GENERAL/CONSTITUTIONAL | | | |
| EAR, NOSE, THROAT | | | |
| CARDIOVASCULAR-HIGH BLOOD PRESSURE | | | |
| RESPIRATORY | | | |
| GASTROINTESTINAL | | | |
| GENITAL, KIDNEY, BLADDER | | | |
| MUSCLES, BONES, JOINTS | | | |
| SKIN | | | |
| NEUROLOGICAL | | | |
| PSYCHIATRIC | | | |
| ENDOCRINE-DIABETES | | | |
| 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*

Do you live alone? YES NO

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: cWUgJcbUž.....%dYf XUnž.....&' #XUnž.....(Ž#Um

Physician's Signature: _____ Date _____ Pt. ID# _____