INTERIM MEDICAL HISTORY

Date: ______________________________ **Date of Last Eye Exam**: ____________________________

Name: _____________________________ **Address**: ____

Insurance: __________________________ **Employment**: ____________________________________

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 Aller**gies to medication 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
If Yes, please list ____

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.

			Explanation of Problem
EYES	YES	NO	
GENERAL/CONSTITUTIONAL	YES	NO	
EARS/NOSE/THROAT	YES	NO	
CARDIOVASCULAR	YES	NO	
RESPIRATORY	YES	NO	
GASTROINTESTINAL	YES	NO	
GENITAL/ KIDNEY/BLADDER	YES	NO	
MUSCLES/BONES/JOINTS	YES	NO	
SKIN	YES	NO	
NEUROLOGICAL	YES	NO	
PSYCHIATRIC	YES	NO	
ENDOCRINE	YES	NO	
BLOOD/LYMPH	YES	NO	
ALLERGIES/IMMUNOLOGIC	YES	NO	

FAMILY

Any changes to family medical status (mother, father, sibling, grandparent) ___ Yes ___ No
If "Yes" describe ____

SOCIAL

Do you drink alcohol? ____ Yes ___ No If "Yes" occasional 1/day 2-3/day 4+/daily
Do you smoke? ___ Yes ____ No If "Yes" occasional ½ pack/day 1 pack/day 1+pack/daily

Physician's Signature: ____