

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 your 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 _____

Family History of Glaucoma _____ YES _____ NO

Family History of Macular Degeneration _____ YES _____ NO

SOCIAL

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

Patient History

NAME: _____

DATE OF BIRTH: _____

PAST MEDICAL HISTORY: _____

PAST SURGERY: _____

ALLERGIES: _____

PRIMARY CARE PROVIDER: _____

PHARMACY: _____

DATE	MEDICATION	DOSE	FREQUENCY

Reviewed and Updated: Date/Tech Initials
