INTERIM MEDICAL HISTORY

Name _____ Date _____

Date of **last eye exam** (with complete medical history) _____

What **medications** do you currently take (prescription and over-the-counter): _____

_____

_____

Do you have **new allergies** to any medications, *since your last visit*? YES ☐ NO ☐

If YES, list the medications: _____

Name of Medical Dr.: _____

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	Details
EYES (blur, glare, red, pain, etc.)	☐	☐	
GENERAL / CONSTITUTIONAL (fever, weight loss, etc.)	☐	☐	
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR (high BP, racing pulse, etc.)	☐	☐	
RESPIRATORY (congestion, wheezing, etc.)	☐	☐	
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)	☐	☐	
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)	☐	☐	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)	☐	☐	
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	
NEUROLOGICAL (numbness, headache, etc.)	☐	☐	
PSYCHIATRIC (anxiety, depression, insomnia)	☐	☐	
ENDOCRINE (diabetes, hypothyroid, etc.)	☐	☐	
BLOOD / LYMPH (cholesterolemia, anemia, etc.)	☐	☐	
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)	☐	☐	

FAMILY HISTORY

Any *changes* to family medical status (mother, father, sibling, grandparent)? YES ☐ NO ☐

If YES, please describe: _____

SOCIAL HISTORY

Changes in employment: _____

Changes in marital status: _____

Changes in driving habits: _____

Do you drink alcohol? ..... YES ☐ NO ☐ If YES: ☐ occasional ☐ 1 /day ☐ 2-3 /day ☐ 4+ /day ☐

Do you smoke? ..... YES ☐ NO ☐ If YES: ☐ occasional ☐ ½ pack /day ☐ 1 pack /day ☐ 1+ pack /day ☐

Patient Signature _____ *Date* _____