INTERIM MEDICAL HISTORY

Date _____

Name_____ Date of **last eye exam**

_____

What **medications** (Rx & OTC) do you currently take? _____

_____

_____

Do you have any **allergies** to medications? ☐ YES ☐ NO

If YES, list the medications: _____

_____

Have you had any **major illness** or **injuries** *since your last visit?*_____

_____

_____

Do you ***currently*** have any problems in the following areas? If "YES", please provide information.

	YES	NO	EXPLAIN PROBLEM
EYES			
GENERAL			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
GASTROINTESTINAL			
RESPIRATORY			
GENITAL, KIDNEY, BLADDER			
BLOOD/LYMPH			
MUSCLES, BONES, JOINTS			
SKINS			
NEUROLOGICAL			
PHYCHIATRIC			
ENDOCRINE			
ALLERGIC/IMMUNILOGIC			

FAMILY

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

If YES, describe

_____

_____

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/ day 2-3/day 4+/day

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