# INTERIM MEDICAL HISTORY

Date _____

Name _____ Date of **last eye exam** _____
with complete medical history

List all medications (Rx & OTC) that you currently take.

_____

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

_____

Have you had any **surgeries, major illness** or **injuries** *since your last visit*? ❑ YES ❑ NO

_____

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

| | 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, IMMUNE** | | | |
| **FLOATERS/FLASHING LIGHTS** | | | |

**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) _____

Living arrangements (private home, nursing home, etc) _____

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 1/2 pack day 1 pack day 1+ pack

Physician's Signature: _____ Date: _____