Interim Medical History

Name	Date
Date of Birth	Date of last eye exam
Are you on any **new medications** (Rx & OTC) since your last visit?	
Do you have any **new allergies** to medication since your last visit?	
Have you had any **major illness or injuries** since your last visit?	
Have you had any **surgeries** since your last visit?	

Do you currently have any problems in areas? If “Yes” please provide information.

	YES	NO	Explanation of Problem
Eye			
General/Constitutional (headache, cancer, AIDS)			
Ear, Nose, Throat (sinus, chronic cough, dry mouth)			
Cardiovascular (heart, vessels, high blood pressure)			

Respiratory (asthma, emphysema)			
Gastrointestinal (stomach ulcers, intestinal disease)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (arthritis, osteoporosis)			
Skin (acne, warts, skin cancer)			
Neurological (multiple sclerosis, stroke TIA)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, thyroid)			
Blood, Lymph (cholesterol, anemia)			
Allergic Immunologic (hay fever, lupus)			

Social

Changes in employment?

Marital status (married, divorced, single, widowed)

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 per day 4+ per day

Do you smoke? Yes No

If Yes: occasional 1/2 pack/ day 1 pack/day 1+ pack/day

Patient Signature:

Physician Signature: