

INTERIM MEDICAL HISTORY

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

What **new medications** (Rx & OTC) do you currently take? (site exam where most recent complete list of meds is documented)

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

If YES, list the medications: _____

List any **major illnesses** or **injuries** *since your last visit*? _____

List any **surgeries** *since your last visit*? _____

List any eyeglasses problems you are having _____

List any computer vision problems you are having _____

List any contact lens problems you are having _____

Are you interested in reducing the costs of contact lens solutions? _____

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 _____

SOCIAL

Changes in employment? _____

Marital Status (married, divorced, single, widowed) _____

Spouse's last eye exam date _____ Children('s) last eye exam date _____

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

Physician's Signature: _____